DEPARTMENT OF HEALTH AND SOCIAL SECURITY

WELSH OFFICE

Central Health Services Council

The Organisation of Group Practice

A Report of a Sub-Committee of the Standing Medical Advisory Committee

LONDON
HER MAJESTY'S STATIONERY OFFICE
PRICE 65p NET

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FOREWORD

This report by a Sub-Committee of the Standing Medical Advisory Committee has been submitted to us by the Central Health Services Council. It develops the concept of group practice and outlines the role and place of community health teams in a unified health service. This concept embodies the positive aspects of current community care and the report emphasises the importance of flexibility in organisation and the need for experiment. It thus has equal relevance in the period before unification.

We regard the report as a valuable contribution towards current thinking about general practice and its place in the health service as a whole. We are sure that it will stimulate discussion among all individuals, professions, organisations and authorities concerned with the National Health Service, particularly during the preparatory stage of unification. We for our part shall be giving the report further study, and we have in mind formally to invite the professional and lay organisations most closely concerned to send us their views on the recommendations it contains. We shall then consider whether there is any specific or general guidance which we could usefully give.

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Secretary of State for Social Services

PETER THOMAS
Secretary of State for Wales.

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CONTENTS

LIST OF APPENDICES

INTRODUCTION

In 1968 the Standing Medical Advisory Committee of the Central Health Services Council set up the Sub-Committee whose terms of reference were "To review the working and organisation of group practice, with particular reference to health centres, and to make recommendations". We have met as a full committee on 30 occasions. A selection of group practices and health centres have been visited by members of the Committee (Appendix B). We received written evidence from professional organisations and individuals (Appendix C). Some of those who gave written evidence to us were later invited to give oral evidence to the Committee. We were assisted by the preparation of documents on a variety of subjects by the Department of Health and Social Security.

We have been ably served throughout by the Secretariat of the Committee, Mrs. A. M. Carpenter, Mr. E. W. Craddock and Miss C. M. Douthwaite, whose invaluable help we wish to acknowledge. They had the difficult task of collating a wide variety of documents from many sources.

We have had the benefit of the advice of a number of observers from the Department of Health and Social Security; in particular we would like to acknowledge the help of Dr. T. E. A. Carr, Mr. D. U. Jackson, Miss A. M. Lamb and the late Dr. B. Didsbury.

At the first meeting of the Sub-Committee we decided that no useful purpose would be served by producing a report that looked only to the immediate future. We are not likely to be able to influence events over the next few years, and consequently consider that it would be more helpful if the Committee were to look a little further ahead. Even so we recognise that some of our recommendations go no further than to endorse those made in the Dawson Report (1) more than 50 years ago. We are aware of the need to tailor our recommendations to geographical and local requirements and hope that the general principles may be achieved in different regions by suitable adaptation and evolution of existing services.

All aspects of medical care are interdependent; primary and continuing medical care is especially linked with all other disciplines. Consequently we did not feel able to confine ourselves solely to a study of group practice. Indeed, we believe that it is rarely possible for a Committee to study only one of the medical services without running the risk of making recommendations that will tend to fragment, rather than integrate, the health services.

In the course of our work we became aware of the difficulty in obtaining factual evidence. We have, however, been presented with an enormous quantity of informed opinion. We know that experiments are going on, but in some instances these are not being evaluated nor are the results being applied. We are convinced that there is a need for much more research into the methods of delivering medical care to our society.

Our report falls into two sections: Chapters I and II, and Chapters III to XIII. In Chapter I we consider briefly the background to the report, and argue the need for a general practitioner providing primary and continuing care in the community, and the need for him to be supported by nurses and other colleagues if he is to work efficiently, and we describe what we consider to be his role in group practice. In Chapter II we argue that there are over-riding advantages if the

doctors and nurses work together in groups from the same premises and we discuss the question of the best size of such a group. We then go on to consider the implications of more than one group practising from the same premises and what the advantages and disadvantages may be.

In the subsequent chapters we discuss the requirements of group practice in terms of the nurses, social workers, and secretarial staff who will be needed and how they may work as a team. We then go on to detail the premises and organisation which this team will require and the need for a new system of combined records. We discuss the relationship of group practice with the department of the community physician, the hospital service, and a number of other professions with which we think group practice will be associated in a unified health service. Finally, we discuss the place of group practice in the training of doctors and other professional workers, and the need for, and methods of, research into the requirements of the community and the means of meeting those needs.

Implicit in many of our recommendations is the belief that an efficient and economic system of medical care requires functional integration of the hospital and community services. It also demands that in the future greater emphasis and financial priority be placed upon the development of our community services than has been so in the past.

Semantic problems have troubled us and we think it wise to define some of the terms we use in our report:

Group practice

We use this term to describe the general practitioners and nurses who together provide primary and continuing medical care; who share the same equipment and secretarial staff and usually the same premises; who provide emergency and off-duty cover for each other and with whom, as a group, other specialists in medicine and other professional workers may be associated.

Basic unit within a group practice

We use this term to describe the sub-group formed by a doctor supported by nurses and secretarial staff, who all relate their work to a defined population. A number of these basic units group together to form a group practice (defined above).

Multiple group practice

We use this term to denote a number of group practices (defined above) who work from the same premises.

Primary physician

The doctor of first contact.

Community physician

We explain, in Chapter IX, what we think are the functions of the community physician in relation to group practice.

Medicine in the community or community care

We use these terms to distinguish medicine outside the hospital from medicine in the hospital although we accept that the hospital is part of the community. We think these terms more apt descriptions than, for example, domiciliary medicine.

Community nurse

We use this term to describe a person who undertakes work combining the skills of a health visitor and district nurse.

Practice nurse

We use this term to describe a nurse who is now usually employed by general practitioners and who works predominantly in the general practitioner's premises.

Health centre

We use this term to describe premises provided by a Local Health Authority under Section 21 of the National Health Service Act, 1946.

Group practice premises

We use this term to describe premises for group practice other than those provided under Section 21 of the National Health Service Act, 1946.

Group practice centre

We use this term when we are talking in general about health centres and group practice premises.

Best-buy hospital

We use this term to describe the experimental projects conducted by the Health Departments to find the most economical and flexible design for hospitals which will ensure greater efficiency, maximum use of space and the maintenance of a high standard of care. It is inherent in this concept that hospitals are planned as part of an integrated community health service in which all three branches of the National Health Service will play their full part to ensure that, through co-ordinated medical care, the most effective use can be made of hospital beds and treatment facilities.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

The Historical Background to the Report—Chapter I

(1). The primary object of all medical care is to meet the health needs of the individual and the society in which he or she lives; medicine must be integrated with other skills and disciplines, and there must be a balance between care within and outside the hospital. (Paragraph 11)

(2). We believe that, in this country, at this time and in the foreseeable future, medical services to the community can best be organised around a general practitioner who provides primary and continuing care for a defined group of people for whom he is responsible. Within group practices* each doctor should care for a defined list of patients who should register with him. (Paragraph 25)

(3). Financial priority should be given to the community health services. (Paragraph 117)

(4). The maximum amount of work should be handled in the community and as little as possible in hospital. There is a need for an efficient medical care service* in the community, integrated both locally and regionally, and with well-defined lines of communication between the different disciplines and services. Unification of health services' administration would be an important step in achieving this aim. (Paragraphs 14–15)

(5). The general practitioner has a definitive role which distinguishes him from other specialists. Vocational training is necessary for all future general practitioners. We do not favour general practitioners confining their work exclusively to certain fields of medicine or particular age-groups but there is an opportunity for them to develop special fields of interest. (Paragraphs 19–32)

(6). To deploy his skills to the maximum advantage a general practitioner needs the assistance of nurses, like the present health visitor and home nurse, whose work is related to the same registered population and who are based on the same premises as the doctor. (Paragraphs 27–28)

(7). Both doctors and nurses need to be supported by secretarial staff. There are great advantages in the attachment of individual members of the secretarial staff to each doctor and nurse. The team of doctor, nurse and receptionist together form the basic unit* within a group practice* for the delivery of medical care to a defined population. (Paragraph 28)

(8). Social medicine should not be divorced from clinical medicine. The community physician* would be a suitable co-ordinator of the social services and the health services if these are to remain separate. (Paragraph 17)

(9). There is need to look continuously and critically at the whole system of medical care and we suggest that future committees should be set up to study all aspects of medical care for a particular area or group of patients and not merely to study separate parts of the health service. A health service based on a general practitioner in the community is likely to be both more effective and cheaper than a hospital-based service. (Paragraphs 12 and 22)

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*See definitions on pages 2 and 3.

Group Practice—Chapter II

(10). Much of the medical work required in the community can be undertaken by the basic unit* caring for a defined population. This basic unit will preserve the important features of personal care, and, of almost equal importance, secure good communication within the team. (Paragraphs 33–34)

(11). The members of each basic unit* within a group practice* should normally relate their work to a constant patient population. (Paragraph 40)

(12). A number of basic units* need to be amalgamated into a group practice* if they are to provide cover for one another, make economic use of accommodation and equipment, and be able to work effectively with other services. (Paragraphs 34–36)

(13). We anticipate the optimum size of a group practice* will be found to be 5 or 6 doctors together with appropriate nurses and secretarial staff. (Paragraphs 38 and 39)

(14). Individual practices within a group may retain their financial identity without detriment to the functional unity of the group. (Paragraph 37)

(15). We consider that providing pathology and radiology facilities within a community care unit* cannot be justified and that these facilities are best concentrated at the district general hospital. (Paragraph 43)

(16). The possible advantages of arranging specialist consultations in group practice centres* should be investigated in experimental schemes. (Paragraph 44)

(17). In urban areas particularly, a number of group practices* could, with advantage, work from the same premises : these premises we term multiple group practice centres.* (Paragraphs 41–42)

(18). Group practice* will help to provide a higher quality service to the community, but may not enable doctors to care for more patients. (Paragraphs 45–46)

The Nursing Staff in Group Practice—Chapter III

(19). We think it necessary to look afresh at the need for community nursing services. (Paragraph 49)

(20). The nursing needs of group practices* are those of the community as a whole, and can be classified as:

(i) traditional nursing care outside the hospital. (Paragraphs 51–52)
(ii) delegated work as agent of the doctor. (Paragraphs 56–57)
(iii) domiciliary midwifery. (Paragraph 55)
(iv) preventive medical care. (Paragraph 53)
(v) health education. (Paragraph 53)
(vi) medico-social work of a limited nature. (Paragraph 54)

(21). The work we describe can be performed by nurses of similar role to the present health visitor and home nurse supported by state enrolled nurses and

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*See definitions on pages 2 and 3.

ancillary nursing help; and in this traditional pattern we recommend that each basic unit* should contain a health visitor and a home nurse. This may not be the best arrangement and there is an urgent need to experiment with other methods, particularly those that break down sharp distinctions between the roles of different types of nurse. (Paragraphs 58–64).

(22). The community physician* will need some nursing services to perform functions not directly connected with group practice.* (Paragraph 65)

(23). The nurses in a group practice* should be directed by a senior nurse responsible both to the practice doctors and the chief nursing officer of the area. (Paragraph 67)

(24). Nurses in group practice* need accommodation, secretarial assistance and adequate transport facilities. (Paragraph 69)

(25). A large proportion of nurses should receive part of their training in selected group practices.* (Paragraph 70)

(26). More nurses will be needed in the community services but this need not be at the expense of the hospital service as use can readily be made of nurses who want part-time work near their homes. (Paragraph 71)

Social Work and Group Practice—Chapter IV

(27). The nature of the social work arising in general practice demands a team approach to the problem. (Paragraphs 77–78)

(28). An artificial distinction should not be made between the social and medical aspects of a particular patient's problems. (Paragraph 72)

(29). We recommend that social workers should be attached to group practice* for case work, and to make assessment of psycho-social problems. They would be ideally placed to undertake preventive and case-finding work. (Paragraphs 75 and 77)

(30). The health visitor, with her nursing background, has an important role to play in dealing with many of the day-to-day social problems associated with ill-health and should work closely with the practice social worker (Paragraph 79)

(31). A need for social workers in group practice* has been established but it is necessary to make a careful assessment of their role in this field, to determine the training they will require to fit them for this work, and to estimate how many will be needed. (Paragraphs 77 and 81)

(32). Although an area office of the Social Services Department should be close to, we do not recommend its inclusion within, a health centre.*

(33). Home helps should be part of the group practice* team. (Paragraph 82)

(34). Voluntary agencies need to be brought into close contact with the community care* team and suitable co-ordinating links and lines of communication should be established. In this, both the health visitor and the social worker have an important role. (Paragraph 83)

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*See definitions on pages 2 and 3.

The Secretarial Staff of Group Practice—Chapter V

(35). General practitioners and nurses must have adequate secretarial staff. (Paragraph 85)

(36). Secretarial staff are needed in group practices* for work involving contact with patients, handling of records, typing, technical procedures and management. (Paragraph 87)

(37). These functions can well be performed by receptionists, records clerks, medical typists and practice managers, but the precise way in which these tasks are allocated is the responsibility of the professional staff in a group practice.* Technical procedures should, as now, be undertaken by nurses, but there should be experiments in extending the training of receptionists to cover technical procedures. (Paragraphs 89–90)

(38). In view of the exacting nature of the work of the receptionist and her special responsibilities, her role merits special attention. Training, particularly in-service training in selected group practices*, should be provided for receptionists as distinct from medical secretaries. (Paragraphs 91 and 95)

(39). The professional staff of a group practice* should appoint and share the secretarial staff who should also, if necessary, serve the professional staff of the community physician* or visiting hospital staff. (Paragraphs 86 and 105)

(40). A patient should have to deal, either in person or on the telephone, with as few people as possible. We see advantages in training secretary/receptionists who would be able to undertake both the reception and the office work generated by a basic unit* and we think this suggestion merits further study. (Paragraphs 91–92)

(41). The Health Departments and representatives of the profession should seek to ensure that doctors are not penalised financially by providing themselves and other members of the group practice* team with adequate secretarial help. (Paragraph 94)

The Premises for Group Practice—Chapter VI

(42). The increasing popularity of health centres* amongst general practitioners is due partly to the advantages that doctors see for patients and partly to the cost of providing their own modern group practice premises* designed to accommodate the health team. (Paragraphs 98–99)

(43). The health centre* building programme should be accelerated and completion times reduced so that the community aspects of the health service are established in time to match the development of district general hospitals. It is also important to take advantage of the present momentum of building and favourable climate of opinion. (Paragraphs 113–114)

(44). Primary medical care will, in the future, be based upon larger units in the community which must be strategically sited in relation to a variety of community services. This will demand judicious area planning and an established consultation procedure. (Paragraphs 103 and 109)

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*See definitions on pages 2 and 3.

(45). Information on existing health centres* and their impact on the quality of community care* should be collected, evaluated and widely distributed. (Paragraph 116)

(46). The size of group practice centres* will depend upon the geographic and social characteristics of the area, the nature of the other health and social services, and the need to preserve the identity of the participating practices. (Paragraph 109)

(47). The needs of rural areas may sometimes be met by means of a central group practice centre* supported by satellite units providing basic facilities only. (Paragraph 110)

(48). If a health centre* is built in the grounds of a district general hospital, physical separation of the buildings is desirable. (Paragraph 112)

(49). The design of group practice centres* should be based upon a thorough study of user requirements, accompanied by an on-going review of the functions of existing health centres.* (Paragraph 104)

(50). Health centres* should be attractive to patients and should be sited, designed and constructed to permit adaptation to meet the needs of the future. Experimental projects should also be established. (Paragraphs 44, 103–104, and 107)

(51). In the future each doctor will require his own consulting room within a group practice centre.* (Paragraph 108)

(52). In some areas it may be necessary to provide over-night accommodation in health centres.* (Paragraph 111)

(53). At the present rate of building it is estimated that by 1975 only 12.5 per cent of general practitioners will be able to practise from health centres;* it will be necessary, therefore, to give every encouragement to general practitioners providing an efficient service from group practice premises.* General practitioners who take steps to provide improved group practice premises providing the full range of services should be protected from capital loss if they subsequently transfer to health centres.* (Paragraph 102)

Equipment, Services and Organisation in Group Practice—Chapter VII

(54). Again we emphasise the general practitioners' need for open access to the diagnostic facilities provided in hospitals. (Paragraph 118)

(55). Future plans should take into account the likely expansion in the use by general practitioners of hospital diagnostic services. (Paragraph 121)

(56). Some items of diagnostic equipment should be provided at group practice centres.* (Paragraph 122)

(57). The peripheral deployment of radiological and pathological facilities in health centres*, however large, is likely to be uneconomic, and general practitioners must therefore have good access to these services at the district general hospital. Arrangements should be made for efficient transport facilities for both patients and specimens and for a quick reporting service. (Paragraphs 118–121)

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*See definitions on pages 2 and 3.

(58). There is a need to rationalise the provision of a variety of health service supplies including sterile dressings and instruments. (Paragraph 123)

(59). We recommend the continuation of experiments in the provision of transport to bring patients to group practice centres.* (Paragraph 124)

(60). The management and organisation of group practice* should be the responsibility of all those working in the group practice, and there should be an accepted and recognised pattern of meetings of the staff of the group practice.* (Paragraphs 125–127)

(61). Members of a group practice* should be consulted about the selection of professional staff with whom they will have to work. (Paragraph 128)

(62). An appointment system is an indispensable feature of group practice.* (Paragraph 130)

Records for Group Practice—Chapter VIII

(63). The present National Health Service medical records system in general practice needs revision in the interest of the patient and for research purposes. (Paragraphs 132–133 and 138)

(64). Records are essential to continuity of care, and an integrated system of recording should be designed for group practice,* and should incorporate the information obtained by all members of the group practice team. (Paragraphs 134, 138 and 140)

(65). An ideal records system for group practice* should provide all the important information about a patient; maintain the confidentiality of the information given to individuals; serve as a means of operational, clinical, and epidemiological research and be capable of being linked with records of other sources. Moreover it must be so designed as to encourage the staff of group practice to maintain it in a proper manner. (Paragraph 141)

(66). A new and flexible record system should be designed which would be suitable or adaptable for either manual operation or data processing techniques. (Paragraphs 138 and 143)

(67). A committee should be set up to consider the detailed design of a record for the group practice* team, and to study the requirements of record linkage with the hospital service. (Paragraph 143)

(68.) All members of the group practice* team should be made aware of the need to maintain confidentiality. (Paragraph 139)

(69.) A standard personal record card is only likely to be used effectively when supplied to patients in particular risk groups. (Paragraph 145)

Group Practice and the Community Physician—Chapter IX

(70). The role of the community physician,* outlined in the Green Papers (1970), will affect the work of group practice.* (Paragraph 146)

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*See definitions on pages 2 and 3.

(71). We see the role of the community physician* as being primarily to obtain an overall view of the total health needs of an area, to identify needs that are not being met and to maintain a balance between the various parts of the health service, using all the resources available to him. (Paragraph 147)

(72). The community physician* should also organise and administer those services which can only be effectively provided for the population of an area as a whole, and should have responsibility for co-ordination with the social service departments and the local authority. (Paragraphs 148–149)

(73). There should be community physicians* working in close association with the group practices* in their area. There should be no duplication of work between the community physician and the group practices. (Paragraphs 150–151)

(74). It is as important to reduce to the minimum the number of persons simultaneously giving clinical care to each patient as it is to avoid duplication of services. We therefore see the role of the community physician* as mainly in identifying new needs and, with his specialist staff, developing and integrating new services. (Paragraphs 152–153)

(75). The community physician* should be involved in teaching at all levels and part of his own training should include experience in general practice. (Paragraphs 155–156)

(76). The community physician* will have important duties in an advisory capacity to a number of other bodies, particularly in the interim period before a unified structure for the health services emerges. (Paragraphs 157–158)

The Relationship of Group Practice* with other Disciplines and Professions—Chapter X

(77). Rehabilitation of the sick and injured is a continuous process involving many agencies both in the hospital and in the community. The general practitioner is primarily responsible for the individual care of the disabled living in the community, and the advice of members of a group practice* may be vital to the correct management of patients' problems. (Paragraphs 159–160)

(78). There is a need for some physiotherapy services outside the hospital and these could probably best be provided in association with the group practice team. The staff required, who might be part-time, could be recruited from the substantial numbers of physiotherapists who are not practising. Training needs to be provided for general practitioners in the modern concepts and uses of the physiotherapy services and there needs to be a close integration of these services in the hospital and the community. Conditions requiring physiotherapy and rehabilitation treatment arise in patients other than those who have received hospital care. This need cannot be satisfied by existing hospital resources but could be met by a physiotherapist working with a group practice team. Such a physiotherapist would need accommodation and equipment. (Paragraphs 162–170)

(79). There are obvious advantages if the pharmacist and doctor can work either from the same premises or in close proximity to one another. At the earliest

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*See definitions on pages 2 and 3.

possible stage in the planning of group practice centres* consultation should take place with representatives of the pharmaceutical profession in the area to ensure provision of pharmaceutical services. (Paragraphs 171–175)

(80). Chiropody services can be readily provided at group practice centres.* (Paragraph 176)

(81). It is uneconomic to provide in health centres* dental services solely for priority groups. Clinical, organisational and financial advantages might follow the provision of dental facilities in group practice centres* though no group (medical) practice centre providing dental facilities should contain less than two dentists. Both ethical considerations and present methods of remuneration raise obstacles to doctors and dentists working together in group practice.* Nevertheless, there are advantages if dentists providing the full range of general dental services work from the same premises as doctors. We recommend that experiments should take place and that the results should be studied by both professions. (Paragraphs 177–180)

The Relationship between the Hospital and Group Practice—Chapter XI

(82). The interdependence of the community and hospital-based medical services must be recognised and medical care should be provided in the appropriate medical and social context. (Paragraphs 181–183)

(83). The aim should be to care for people at home when they are ill unless the specialist services within the hospital are necessary. (Paragraph 184)

(84). Economic as well as humanitarian advantages would probably follow a change of emphasis from the hospital towards care in the community. (Paragraph 185)

(85). The development of the district general hospital is likely to intensify the difficulties associated with removing some patients, particularly the elderly, to hospital. (Paragraph 183)

(86). The standards of general practice are enhanced if general practitioners have access to hospitals. Most general practitioners could undertake the care of some patients in hospital provided it were easily accessible. This may be an important argument in favour of retaining some of the smaller hospitals. (Paragraphs 186–187)

(87). At the present time substantial numbers of patients are inappropriately using costly hospital services. Social necessity, rather than medical need, accounts for the presence of many patients in hospital: these do not require any greater medical or nursing attention than could be given by the community care* team and they could, with advantage, be cared for in nursing units. (Paragraph 191)

(88). Some nursing units might be based on existing cottage hospitals whilst others might be established in close proximity to group practice centres.* There is a need for experiment with different methods of providing nursing care in the community to avoid admitting some patients unnecessarily to the district general hospital. (Paragraphs 195 and 200)

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*See definitions on pages 2 and 3.

(89). We would expect the cost of providing such care to be less expensive than providing beds in the large hospital. There is insufficient evidence to demonstrate this and comparative cost figures should be produced. (Paragraph 193)

(90). General practitioners either now or in the future are unlikely to be able to undertake full clinical responsibility of patients in general hospital beds. (Paragraphs 196 and 199)

(91). General practitioners could make a most useful contribution to hospital work by participating as members of the hospital team. (Paragraph 197)

(92). If the Peel Report recommendations are adopted, then more general practitioner obstetrics beds will have to be provided in the joint general practitioner/consultant units within the district general hospital of the future. (Paragraph 198)

(93). There is little evidence of a need for direct access to long-term beds for the chronic sick. General practitioners who undertake such care should do so as integral members of the geriatric team. (Paragraph 199)

(94). Holding hospital out-patient sessions in group practice centres* away from the hospital would help strengthen liaison between the hospital and community services. The advantages to be gained outweigh the disadvantages and we recommend that pilot schemes of community-based consultative clinics should be established. (Paragraphs 202–203)

(95). All group practices* should be equipped and able to deal with minor injuries and casual attenders, thus relieving the hospital accident and emergency department of inappropriate work. (Paragraph 204)

(96). In some rural areas there will be a need for more sophisticated first aid before patients are conveyed to the more distant accident centres. This could best be provided in existing cottage hospitals or health centres.* (Paragraph 205)

(97). In future more general practitioners will be involved in some aspect of hospital work. We anticipate that there will be an increase in the readiness with which consultants come out of hospital to consult with general practitioners and hold consultative sessions in group practice centres.* (Paragraph 206)

(98). After-care and the long-term management of chronically ill patients require the closest possible communication between general practitioners and hospitals. There is no single way of achieving this communication but we have indicated a number of ways in which group practice* and health centre* practice can facilitate this. (Paragraphs 208–210)

The Role of Group Practice in Education—Chapter XII

(99). We welcome the steps being taken to remedy deficiencies in the training of general medical practitioners. Information should be collected and kept under review about the extent to which practice needs, both present and future, are met by the training curriculum. (Paragraphs 211 and 215)

(100). In the future the necessity for vocational training should be an accepted pre-requisite for new entrants to general practice and some form of assessment of

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*See definitions on pages 2 and 3.

the training will be required. Such training is likely to attract, rather than deter doctors from entering general practice. (Paragraphs 213–214)

(101). Since all medical students will need to have an insight into practice outside the hospital, university departments of general practice should be based upon group practice centres* in close association with the teaching hospital. Such centres should combine the functions of service with those of teaching and research. (Paragraph 216)

(102). There will also be a need for a number of additional teaching practices associated with the academic department of general practice in the medical school. (Paragraph 217)

(103). The selection and supervision of teaching practices should be the responsibility of Regional Postgraduate Committees. Group practices* will also have a part to play in the training of nurses, health visitors, social workers, and secretarial staff. (Paragraphs 218–219)

(104). A specified doctor should act as tutor to medical students and trainee practitioners, and some way should be found to compensate for the time spent on teaching. (Paragraph 223)

(105). Provision should be made for accommodation for teaching purposes in group practice centres.* (Paragraphs 221–222)

The Opportunity for Research in Group Practice—Chapter XIII

(106). There is insufficient organised research into the health services and how they are provided. Studies should be mounted to evaluate group practice,* and should include the study of health centres* and the way in which they operate. These should be a function of the community physician* of each area health authority under the direction of the Health Departments who should also correlate and disseminate the results. (Paragraphs 225–227)

(107). Universities and medical schools should devote more time to research into the medical needs of the community and how they may be met. (Paragraph 228)

(108). Epidemiological research can and should be done through group practice* but success will depend on an adequate record system. (Paragraph 229)

(109). General practice provides opportunities for effective research which are enhanced by the continuing relationship between the doctor and patient. (Paragraph 230)

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*See definitions on pages 2 and 3.

CHAPTER I

THE HISTORICAL BACKGROUND TO THE REPORT

1. Group practice is simply a method of general practice, that is an integral part of the health service which has evolved in this country. The origins of this scheme of medical care date from the Medical Act of 1858 which provided a register of qualified doctors and removed the distinction between apothecaries, physicians and surgeons. The concept of the general practitioner followed the necessity for specialisation in medicine as a result of the sudden growth in the amount of medical knowledge, and of advances in medical technology which began in the later years of the last century and which have progressed with increasing rapidity ever since.

2. The National Health Insurance Act of 1911 provided the legislative framework for a general practitioner service for certain groups of compulsorily insured workers. But, because this Act did not provide for the dependants of these workers, the aged, nor for some other needy sections of society, the local health authority began to undertake a measure of personal medical care in the form of ante-natal and child welfare work, in addition to their traditional public health role. Specialisation gradually increased between the two world wars and the specialist became increasingly dependent upon the facilities of the hospital, in whose activities the general practitioner played a decreasing part. It became an accepted ethical principle that the specialist saw only those patients who were referred to him by a general practitioner. In this way the three branches of the Health Service system—the Hospital Service, the Local Health Authority Service and the General Practitioner Service—evolved separately with some overlapping functions.

3. The Dawson Report of 1920 (1) recognised the requirement for an overall plan for the health services and, in particular, the need to integrate functionally the three branches of the service. This report first mentioned the concept of the health centre as providing a focal point from which medical care could be provided for a defined area, and at which the hospital and community health services could meet. For various reasons, which are not relevant to this report, the recommendations of the Dawson Report were not implemented and the three branches of the Service were carried over into the National Health Service in 1948, each with its own separate administration. At the same time, however, the concept of the general practitioner was built into our health care system and ensured the continued existence of this form of medical care at a time when it was disappearing in some other countries, notably the United States of America.

4. The National Health Service Act 1946, conferred upon local health authorities the duty to provide health centres, and in 1948 a number of premises were recognised as health centres to enable the services being provided from them to continue. Very few centres were built in the following years, because of both central and local difficulties, and the majority of general practitioners continued to work as they had done previously, usually from their own residences but later from

purpose-built or adapted premises. The increasing popularity of partnership practice since the introduction of the National Health Service (Appendix F, Table 1) has been due to a variety of factors including the organisation of emergency cover and off-duty times and the obvious attraction of shared overhead costs.

5. Following the introduction of the National Health Service Act, 1946, the role of the general practitioner became confused. The national hospital service was being planned on a regional basis, but the hospitals continued to retain a measure of responsibility for primary and continuing medical care, which they were previously accustomed to provide for the more needy sections of the population through the medium of the Casualty and Out-Patient Departments. The local health authority also continued to provide certain personal medical services which, in some instances, duplicate the work of the general practitioners.

6. A very critical report by Dr. Collings (3) received much publicity which tended to overshadow more constructive publications such as the Cohen Report (4), and Stephen Taylor's "Good General Practice" (5), both of which appeared in 1954. The Cohen Report drew attention to the increase in efficiency and quality of service which could be attained by general practitioners working in groups from common surgery premises with the support of ancillary staff and this report was followed by the setting up of the Group Practice Loans Fund. The trend thus set gathered momentum. When in 1963 the Gillie Committee reported on "The Field of Work of the Family Doctor" (6) it reiterated the advantages of this form of organisation, and there has been a steady increase in the number of doctors working in groups. This is exemplified by the mounting number of partnerships of three or more doctors shown in Appendix F, Table 1. In 1966, following the joint discussion between the Government and the medical profession of the "Charter for the Family Doctor Service", this form of practice was recognised and encouraged by a special payment to three or more doctors—two in some rural areas where the population would not support a larger number—who practise in close association from a common main and central surgery and employ ancillary staff. Over half of all the general practitioners in England and Wales now practice in groups (see Appendix F, Table 2). The expenses of providing practice premises and ancillary help are partly met by direct reimbursement.

7. The Gillie Report also drew attention to the change in the pattern of mortality and morbidity consequent on advances in preventive medicine and in therapeutics, which had resulted in the disappearance or easy cure of many of the acute infectious diseases, and the increasing predominance of chronic disease, degenerative conditions, and developmental disorders. It stressed, as later did the Sheldon Committee (7) on Child Welfare Centres, the need for doctors in the community to work in close association with other workers in the medical and social fields and drew attention to the advantages which followed the attachment of nurses, midwives and health visitors to individual practices.

8. The succeeding years saw a large number of such schemes come into operation. In the last few years there has evolved the concept of a group practice team composed of doctors, nurses and social workers supported by secretarial staff working from common premises.

9. General practitioners still find it increasingly difficult, in spite of help from loans, to provide the premises and equipment necessary to undertake their role

efficiently. In some places the cost of obtaining land on which to build, or premises suitable for conversion, is prohibitive. We were told that young doctors in particular lack the financial resources to invest in purpose-built premises. What is available to them is usually needed to secure a motor car and a house. The same factors have almost certainly led to the renewal of interest in health centres which is reflected in the number which have now been constructed or are in various stages of planning. Between 1948 and 1963 only 17 health centres were built in England and Wales. In the six years 1964 to 1969, 122 new centres were opened and at 31 December 1969 there were 94 under construction and a further 77 approved for building (Appendix F, Tables 3 and 4). The distribution of development is uneven for a variety of reasons, some of which are obvious and others not so clear (Appendix F, Table 5). If this pattern of development continues most general practitioners will, in the not too distant future, be working together with nurses and other workers from health centres or in purpose-built or adapted group practice premises.

10. Concurrently with the developments described above there has been emerging the generally expressed opinion that the health service system requires functional and administrative unification. In July 1968 the Minister of Health published a Green Paper (13) putting forward tentative proposals for the reorganisation and unification of the administrative structure of the medical and related services in England and Wales. The discussions and comments which followed resulted in the Secretary of State for Social Services and the Secretary of State for Wales each publishing a Green Paper (2) in 1970 setting out revised proposals for an integrated health service. The new administration announced in November 1970, that they intended to unify the administration of the National Health Service under health authorities which were outside local government but which worked closely with the local authorities responsible for the personal social services and the public health service. They were not satisfied, however, with the detailed administrative proposals in the 1970 Green Papers. This then is the background from which the Sub-Committee have proceeded to work.

The Objects of Medical Care

11. The primary object of all medical care is to meet the health needs of the individual and the society in which he or she lives. Caring for the sick and maintaining health is a continuing process in which a number of different skills are involved. The contribution of the doctor may be great or small. His role may be in close association with patients and their families, in hospital or in some community setting. The needs of the patient, however, may be in each of these areas. Consequently we have to provide a setting in which medicine is closely integrated with other skills and in which different disciplines work together easily. We also need to provide a service in which there is an efficient balance between care within and outside the hospital, taking account of the available resources both in terms of manpower and finance.

12. Technological advance has already extended the scope of hospital practice and encouraged the development of specialisation. In the future it is likely to have an increasing influence on the practice of medicine outside the hospital in the patient's own environment. If medical manpower is to be deployed economically there is a need to look continually and critically at the whole system of medical care, within hospital and outside because these are inter-dependent. For this

reason we suggest in terms of the services needed by a particular group of patients of a specific population, it would, in the future, be preferable if committees were not set up to deal with individual aspects in isolation.

13. The evolution of the system of medical care in the community has, in some instances, failed to keep pace with advances in the science and technology of medicine and with the changing role of doctors and other workers. The education of both the doctors and the other workers has also failed to keep pace with these changes. The Report of the Royal Commission on Medical Education (8) and its recommendations regarding vocational training for doctors lends support to this view and evidence was presented to us that the training of nurses, health visitors and social workers has not always been designed to enable them to work effectively in group practice.

14. We received evidence that there has sometimes been an over-emphasis on the role of the hospital in medical care, and to some extent an over-use of a costly hospital service. At any one time approximately 0.8 per 1,000 of the population are to be found in hospital, but many of these patients do not appear to be in need of the skills of the hospital specialist or the facilities of the hospital. We discuss this in Chapter XI. It is also evident from a study of the results of a variety of investigations and reports, that a considerable number of people attending the out-patient departments of our hospitals do not need the skills of the consultant specialist or the facilities of the hospital. Indeed there is evidence in some cases that the follow-up by hospital departments duplicates the work of the general practitioner by assuming an inappropriate measure of continuing care for patients who could safely be discharged to the supervision of their general practitioners. We believe that the maximum of work should be handled in the community setting and as little as possible in the hospital.

15. In the context of current patterns of morbidity, in which chronic and degenerative diseases predominate, the task of the doctor, once the diagnosis has been established, lies largely in limiting the degree of disability and in helping the individual and family to adapt to the problems which arise. For this reason much ill-health is better understood, and consequently can be better managed, in the patient's own environment provided that the appropriate equipment and knowledge can be deployed there. There is a need for an efficient medical care service located in the community. This should provide continuing care, supporting but equally dependent upon the hospital and embracing all aspects of illness including those of social and psychological origin, and dealing with preventive medicine and health education. The concept of the district general hospital depends upon a high quality service of this nature, which moreover is in the best interests of the individual patient.

16. If this object is to be achieved, the system of medical care needs to be functionally integrated both locally and regionally, and the lines of communication between the different disciplines and services involved in the maintenance of health and in caring for the sick must be well defined. It was evident from the report "Working Together" (1968) (9) that a great deal had been done to integrate and achieve co-ordination between the three existing branches of the service. Excellent progress has been made especially in the field of integrating the local health authority and general practitioner services, but the impression given by the report is that the effort required to obtain co-ordination is out of all proportion to the results achieved and is far from uniform. The views expressed in the reports

of the Royal Commission on Medical Education, the Sheldon Report, the Maude Report (10) and the Peel Report (11) suggest that the present system will be rendered archaic and that we shall inevitably be driven to unification of the health services. The reaction to the Porrit Report (12) and, more recently, the Green Papers (2, 13) has shown a large measure of unanimity in favour of unification of the health services, although there are differences of opinion as to how this can be achieved. For the reasons outlined above, we assume that unification of the health services will take place and consequently throughout our report we try to examine how group practice and health centre practice can best fit into this pattern.

17. At the same time we are well aware that administrative unification of the health services will, in itself, achieve little unless accompanied by functional integration. We must avoid the situation whereby groups of physicians and related medical workers are isolated into compartments which inhibit communication and can only be changed by violent upheaval. For these reasons we doubt whether the administrative separation of the social services from the medical services, established by the Local Authority Social Services Act, 1970, will be satisfactory. The Seebohm Report (14) has made an effective case for the integral organisation of social work as a discipline in its own right, but in so doing has gone so far as to threaten to separate the health and social services at a time when general opinion would appear to favour integration. We concur with the view expressed in the report that there is a need for team work and we welcome the suggestion that social workers should be part of the group practice team (paragraph 700) and have the same standing as any other professional group. We are convinced that social aspects of medical care cannot be divorced from clinical aspects and that it is essential that some person should act as a co-ordinator if the social services and health services are to be administratively separated. We suggest that the most suitable person to perform this function would be the community physician and we discuss the problem further in Chapter IX.

18. It appears to us that the recommendations of the Royal Commission on Medical Education and, in particular, those concerned with the teaching of medicine outside the hospital and the post-graduate vocational training of general practitioners, have received general acceptance. Consequently, we have also examined our subject with the assumption that all general practitioners will receive vocational training for general practice and will as a result, be adequately trained.

The Need for a Generalist in the Health Service

19. As specialisation in medicine progresses there is an increasing need for the individual person to have access to a personal physician, who will act as a doctor of first contact. But as specialisation increases, fewer doctors will be in a position to provide both primary and continuing care. There is an inherent conflict between the needs of a specialist and the demands of primary medical care. To remain skilled the specialist must concentrate his experience in a limited field, but the primary physician cannot do this and also be available for all types of illness. Conversely, if the generalist working in the community is going to be able to fulfil his special role, then it is improbable that he could without detriment to his efficiency also be a specialist in a hospital discipline. A further consequence of specialisation and fragmentation of medicine is the necessity for a doctor

to be in a position to mobilise the specialist services in an integrated way for the individual patient. The Gillie Report summarised this in the following passage:

> "He acts as the essential intermediary in the transmission of specialised skills to the individual. Without this function of the personal doctor the hospital service can be used wastefully, even damagingly to the patient. This involves assessment of the patients' requirements and selection of the appropriate consultant and department. The family doctor must interpret the patient, his problem and circumstances to the consultant, explain the need for hospital service and its possibilities to the patient and ensure the necessary communication with all concerned including the relatives. It is he who secures the essential after-care in the training of the patient in recovery or adjustment to handicap and co-ordinates the available resources to this end. The family doctor is the one member of the profession who can best mobilise and co-ordinate the health and welfare services in the interests of the individual in the community, and of the community in relation to the individual."

20. The Gillie Report, in defining the field of work of the family doctor, laid the foundations of a specialty of primary and continuing family medicine. The Royal Commission on Medical Education accepted this concept and suggested a suitable vocational training structure. Prior to the introduction of the National Health Service, the general practitioner largely confined his role to the treatment of those persons who came to him with problems. Since the National Health Service gave each practitioner a defined population for which he was responsible, the general practitioner has become more and more involved in preventive medicine, screening for early disease and health education amongst the group of people for whom he undertakes to provide care. The relationship which a primary continuing physician develops with his patients provides obvious advantages for him to undertake such work, and indeed in some instances the most efficient and economic results can only be obtained in this way. However, at the same time, there is a need to co-ordinate these services for the population of an area as a whole, to fill gaps in the service and to provide for interim arrangements whilst the system of medical care is developed.

21. In addition to high scientific standards, the care of sick people demands the less tangible skills of doctors. These are a personal contribution depending upon a sense of responsibility for patient care. Also, with a limited time available to manage large numbers of patients, the first-hand knowledge of families and individuals, which a general practitioner is able to accumulate, permits greater depth of diagnosis and better care than can be offered by episodic contact between doctors and patients not previously known to each other. For this reason we recommend later (paragraph 33) that general practitioners, whether or not they are working in group practice, should individually take overall and continuing responsibility for a defined population of patients who should be registered with them.

22. A health service based upon the general practitioner is likely to be less costly than a hospital-based service, and certainly a policy of providing the maximum amount of the health services in the community will free the highly trained staff and beds in hospitals for work which demands these skills and facilities. The aim of a high quality service based upon the general practitioner should be primarily to care for people out of hospital, to select and prepare those who need hospital

care, and to ensure that conditions are such that they can be returned to their homes as soon as possible.

23. In this high-quality community service which we envisage, we see an opportunity for general practitioners to develop special fields of interest, in which they become more knowledgeable and skilled, to strengthen their own work and that of the group in general practice. We consider that, within a group practice, the special interests of the doctors should be complementary as they are in many group practices at present. The following are instances of generally accepted special fields of interest in which general practitioners might usefully participate:

(i) Dermatology.
(ii) Geriatrics and rehabilitation.
(iii) Obstetrics, including family planning, ante-natal and post-natal care.
(iv) Ophthalmology.
(v) Paediatrics, including child development.
(vi) Psychiatry.

Familiarity with the work load of general practice indicates that special knowledge of some other conditions such as respiratory diseases, diabetes, cardiovascular diseases, rheumatic disorders and of industrial medicine would be beneficial to a group practice. In these areas the community physician may have an important contributory role not only in ensuring that no group of patients is forgotten in the overall service but also in contributing special knowledge and skills.

24. While we recognise that group practice can afford an opportunity for doctors to develop special interests and skills we have little faith in the concept of practitioners confining their work exclusively to certain fields of medicine or to particular age-groups. Such a system of practice, which has been advocated by some authors in this country (15, 16), and which has developed in parts of the United States, has certain advantages in that the profession is not rigidly divided between specialists and generalists, and there is opportunity for interchange between professional groups. This method of practice, however, ignores the fact that ill-health in one individual is often intimately related to that of another member of the family in a different age-group. Theoretically, consultation between the different specialists can take place, but in practice such close co-ordination is difficult to achieve. It also loses the advantage to the doctor of seeing each new episode against the background of his personal knowledge of the patient's previous medical history, while the gain in specialist experience is very limited since the case material provided by one group practice is inadequate as a basis for specialist practice. It also leads to the situation where an ill person has himself to decide which category of doctor to consult. Our thesis is that a person who is ill needs a doctor who will undertake primary and continuing care even when specialist advice is sought.

25. For these reasons we think that the medical services to the community can most effectively be organised around a general practitioner who provides primary and continuing care to a defined group of people for whom he is responsible himself or, when appropriate, by delegation to known colleagues. In essence this is the concept of the single-handed practitioner and there is a wealth of opinion which favours the view that such a doctor can provide a very high standard of primary,

personal and continuing care for his patients. Nevertheless, for reasons detailed in Chapter II, single-handed practice cannot meet all the demands of modern medical care, and the advantages of practitioners working in groups, together with nurses and social workers and perhaps other professions, are overriding. There is an inherent risk in group practice of losing the invaluable continuing relationship between doctor and patient, which single-handed practice permits, and of medical care becoming more episodic and fragmented. We make specific recommendations to combat this risk (see Chapter II), the aims of which are to ensure that the good features of single-handed practice are carried over into group practice.

26. Some doctors in sparsely populated areas may still have to practise as single-handed doctors, but we believe that even in these circumstances many of the benefits of group practice can be brought to bear by suitable organisation.

27. The general practitioner is increasingly being faced with problems which are a complex combination of physical, behavioural and social factors. He is also increasingly becoming involved in developmental assessment, preventive work and health education. In order to do this adequately, he needs to work closely with and be supported by someone who has special training in preventive medicine, health education and some social work. There are advantages if the individuals who undertake this work have a medical background to their education such as that provided by a nurse's training. If a general practitioner is to deploy his skills to the maximum advantage, he also needs the assistance of a nurse who can undertake the purely nursing aspects of medical care and to whom the doctor can delegate some aspects of his work which are within the capabilities of a nurse. Consequently, the general practitioner needs to work from the same building and in close association with nurses whose functions are similar to the present health visitor and home nurse.

28. For the same reasons that each doctor's work should be related to a constant patient population (paragraph 21) so the work of the nurses should also be related to a definitive group in the community. Furthermore, difficulties of communication and co-ordination between doctor and nurse are reduced to the minimum if an individual doctor and nurse together relate their work to a common patient population, as occurs when a nurse is attached to a single-handed doctor's practice. Both doctors and nurses need to be closely supported by secretarial staff if they are to be able to use their knowledge and skills to the best advantage. Again there are great advantages in the efficient running of appointment systems, and in terms of sympathetic and tactful handling of patients, if individual members of the secretarial staff work closely with each doctor/nurse team to form the basic unit for the delivery of medical care in the community.

29. We are aware of difficulties in applying this principle in its simplest form, and we make specific recommendations in Chapter II on the combination of such units within the group practice. Such an organisation permits retention of the good features of single-handed practice with the advantages of group practice.

The Role of the General Practitioner in Group Practice

30. The Gillie Report discussed the field of work of the family doctor. We do not propose to reiterate all that was mentioned in that document. Any discussion of group practice and health centres should outline, in general terms, the role of a general physician in the community, describe his methods and the content of his

work. We think it important to distinguish between general practice as a specialty and general practice as a system of medical care. The general practitioner, as a specialist, has two well-defined roles:

(i) The diagnosis and management in or near the home of undifferentiated illness in a defined population of individuals or families to whom he is directly accessible and for whom he accepts a continuing responsibility.
(ii) The prevention of disease and the maintenance of health both physical and mental including the detection of the earliest departure from normal in the individuals and families of this population.

These roles distinguish the general practitioner from other physicians. He has to acquire a certain body of knowledge, skills and attitudes which are essential if he is to be able to fulfil these roles. The knowledge required is derived from a number of parent subjects (see Appendix D). The knowledge there described is integrated and applied to the problems and situations of general practice, and the dividing lines have no significance. The general practitioner does not have to be a specialist in any of the parent subjects from which he draws his knowledge any more than an anaesthetist needs to be a physiologist, biochemist or pharmacologist.

31. The traditional methods of medicine are adapted to fit the circumstances of each discipline. For example, the hospital specialist may in many instances assume that a patient's problem is confined to his specialty. The general practitioner can make no such tacit assumptions. Implicit in his role as a primary physician is his availability for all types of disorders. He cannot therefore rely on any single clinical method but has to develop a method which can be adapted to any situation he may encounter. All doctors are limited by economic factors such as the time available and the cost of procedures which are used. These two factors, especially the former, apply with particular force to general practice so that the clinical methods must again be adapted to decide what can be achieved for each patient in the time available, and what is unimportant and may be omitted. One of the features of the work of the general practitioner is the frequency with which he has to make decisions about management even though a complete diagnosis may not have been reached. This lack of certainty of diagnosis is a fact of life for the general practitioner. The decisions which he makes are based upon a consideration of the probabilities derived from a knowledge of the relative incidence of the condition, and the relative frequency with which symptoms accompany specific diseases. He may also be alerted to special risk factors by his previous knowledge of the patient, and he must be alive to the necessity of early investigation of symptoms suggestive of serious disease. In addition to defining the illness from which a person is suffering, the general practitioner is also more concerned than most doctors in relating the diagnosis to the individual and in determining, amongst other things, what the patient's concept of his illness is; what his expectations from the consultation are, and how the patient's temperament, constitution, attitudes and experience will affect the management of a particular ailment. Finally, in many chronic diseases the clinical diagnosis is not in doubt and the problem is to discover why the patient's state of equilibrium has been upset. These considerations illustrate the importance of the general practitioner knowing his patients as individuals and consequently the importance of organisation within group practice to permit this.

32. General practice as a system of medical care, however, varies with the needs of the community, the realities of geography and with the state of development

of the medical services in a particular area. Consequently, the individual general practitioner may be required to undertake a number of other roles such as surgery, obstetrics, anaesthetics, industrial medicine, police work, medical referee work for government departments, and school health work for the local authority and private educational establishments. In the performance of these aspects of his work he is not different from a specialist in the particular field. The extent of the general practitioner's involvement in these fields will change; for example, few general practitioners now undertake any major surgery, and in many areas the range of domiciliary obstetrics has declined to such an extent that many general practitioners no longer maintain the necessary skill in the conduct of the confinement and have, as a result, limited their participation to the ante-natal and post-natal period. This process does not mean that the work of the general practitioner is contracting because, at the same time, it is expanding in other directions. Indeed, as we pointed out in paragraph 17, the National Health Service should be so organised that no physician is in such water-tight compartments that he cannot adapt his role to changing circumstances. Such specialist roles as these, which general practitioners may from time to time undertake, should not become of sufficient substance to detract from his essential role of primary physician responsible for a defined population, nor seriously to reduce his availability to his patients.

CHAPTER II

GROUP PRACTICE

33. In Chapter I we describe what we believe to be the objects of medical care; the need for a primary and continuing physician working in the community, the need for him to be supported by nurses, social workers and secretarial staff, and the role and methods of the general practitioner in this context. We suggest that the nursing and much of the social component of general practice should continue to be undertaken by the present health visitor and home nurse who should, together with the doctor and the secretarial staff, work from common premises and relate their work to the same population. We suggest that these workers can undertake much of the work required in the community. A basic unit of the composition that we have outlined (see paragraphs 27 and 28) will preserve the essential good qualities of single-handed practice and will ensure that patients are able to consult the doctor or nurse to whom they have become accustomed and with whom they have formed a relationship. This relationship can have a significant therapeutic value in some situations and promotes better and more rapid communication between the doctor and the patient, which is consequently of value in terms of the speed and depth of diagnosis when handling large numbers of patients. The continuing responsibility for the well-being of a defined group of persons can elicit a positive attitude of responsibility in those providing the care and, in a demanding occupation, this source of motivation is important. Furthermore, such a basic unit would obviate the danger of medical care becoming impersonal and episodic where large numbers of doctors and nurses work together.

34. We have suggested a basic unit of doctor, nurse and supporting secretarial staff providing continuing care for a defined population. For a number of reasons it is impracticable for such a basic unit to work on its own. A larger group is required to provide cover for off-duty periods, holidays, sickness, and emergency work; for economic use of some items of equipment which we consider essential and to provide a focus for professional contact and mutual support. In addition the number of health visitors currently available is not sufficient to allow a ratio of one health visitor to each doctor, and the same is true of home nurses. Consequently, we think that a number of these basic units should work together as a group practice team from common premises. We recognise that the formation of group practice from the aggregation of a number of basic units is not the only way by which the requirements we outline may be satisfied. We recommend, therefore, that the basic unit system of organisation should not be rigidly followed but should be adapted to suit individual circumstances and that other methods offering similar advantages should also be tried.

35. The staff of a group practice—medical, nursing and secretarial—can provide cover for each other without the involvement of outside agencies such as deputising services. We appreciate the need that has arisen in the past for deputising services, particularly for single-handed doctors or very small practices, but we do

not believe this form of organisation is in the best interest of the patient since the continuity of personal care can be lost. The employment of junior hospital doctors to staff these services in some areas is an unsatisfactory solution since these doctors are already overworked in the hospital and have had little training for general practice. It would be much better if the services in the community were so organised as to be able to provide their own emergency cover.

36. The aggregation of such basic units to form a group practice would enable more efficient use to be made of accommodation and equipment, and would provide effective liaison between the individuals in the group and would facilitate easy communication with the hospital services. A group can also serve as a medium for mutual education, allow the development of special interests (see paragraph 23) by the doctors and the time to pursue them.

37. The doctors in a group can practise in a financial partnership but need not necessarily do so. Since the formation of groups is likely to arise from the coalescence of smaller practices to work from common premises we think it is probable that to begin with, the individual practices will wish to retain their financial identity. We see no reason why this should affect the functional unity of the group.

38. We have received a great deal of opinion as to what the optimum size of the group should be including the suggestion that no definitive decision could be arrived at without further evaluation of the effectiveness of different sizes. It would be very difficult to set up experiments which would provide any real evidence because of the complex nature of the many factors involved such as local needs, geography, personalities, questions of communication and administration, etc. We find that, at present, group practices commonly comprise between three and five doctors but, from a consideration of all the evidence and opinion that we have received, we anticipate that, as time goes on, the optimum size will be found to be five or six doctors.

39. Our reasons for suggesting these figures are that a group of five or six doctors together with the nurses and supporting secretarial staff would be sufficiently large to provide emergency cover for off-duty periods, holidays, and sickness for all the staff. The group would not be so large as to hinder intercommunication. Nor would it be so large as to require an unwieldy administration. A group of this size would be responsible for a population of approximately 15,000 persons. It would provide a useful instrument for the development of preventive aspects of medical care and health education based upon an efficient records system, and for close collaboration with the staff of the community physician, whose role we consider in greater detail in Chapter IX. It would also be large enough to justify the attachment, as advocated by the Seebohm Committee, of one or more social workers whose work would be related to the population of the group practice and who would be able to communicate effectively with the doctors, nurses and health visitors.

40. Notwithstanding the general principle that the internal administration of a group should be left largely to the members of that group, we would stress that for the majority of episodes of care the staff of the basic unit within such a group should relate their work to a common patient population. We will suggest in Chapter VI how this type of group practice may be adapted to areas of sparse population without destroying the essential concept.

41. More than one group practice could well work from the same premises. These might be termed multiple group practice centres and vary in size from a centre for two groups of doctors to a centre for four groups or more. We use the term multiple group practice centre to distinguish this concept from that of the Community Care Unit put forward by Draper and his colleagues (17–20), which we discuss later. For obvious reasons the population and area served by centres of this sort would depend to a large extent upon local geographical features. There is limited experience of multiple group practice centres in this country, although members of the committee have seen several in which there were groups of two, three, four or five doctors working alongside one another. In other countries there are examples of centres in which as many as a hundred doctors work apparently satisfactorily. The advantages which we envisage could result from the development of multiple group practice centres are:

(i) To make the use of more sophisticated equipment economically justifiable.
(ii) Such centres could better serve as a focus for vocational and continuing education.
(iii) Large enough centres of this kind could accommodate a specialist in preventive medicine from the department of the community physician who, amongst other things, would take responsibility for promoting immunisation schemes and health education and for the monitoring of morbidity and epidemiological work.
(iv) Large centres could be the focus through which some of the rehabilitative services could be supplied to the community and would also make it possible and justifiable to accommodate some of the professional workers allied to medicine such as dentists and pharmacists. There are obvious advantages to be gained by these professional groups working side by side and by their being able to communicate easily.
(v) It would be economically justifiable and logistically possible to do much minor work that is currently undertaken in casualty departments of hospitals in centres of this size with consequent relief to the hospital work-load and a reduction in the patient's travelling time.
(vi) Centres with more than one group of doctors practising from them would serve populations of upwards of 30,000 persons. Consequently there would be sufficient work to justify regular visits by hospital consultants in certain specialties to hold out-patient sessions in the centre. We think that this would have a more potent effect in bringing the hospital staff into contact with the general practitioner than for general practitioners to work in the hospital, though this does not mean that we see no place for the general practitioner in the hospital. (In Chapter XI we discuss this question in greater detail.)
(vii) Similarly, large centres containing more than one group of doctors would make it possible to provide some beds with very simple nursing care at or near the centre, and we discuss the value of this in Chapter XI.

42. The possible disadvantages of large premises were stressed by many who gave evidence to the Committee. The first is that patients would have to travel further to consult a doctor. Whilst this is true, it has been estimated that in London no one would have to travel more than $1\frac{1}{2}$ miles to a centre serving a population of 50,000 and not more than 2 miles in the provincial conurbations. We are confident

that this objection can be overcome by suitable siting of the premises in relation to public transport, by the use of appointment systems, by the provision of additional transport and, in rural areas, by small satellite units which are closely associated with the central group practice centres (see paragraph 110). The second possible disadvantage is that larger premises will result in an impersonal service to the detriment of the doctor/patient relationship. This we recognise is a very real danger, but we do not consider that it is inevitable, provided that the following factors are given due consideration:

(i) The staff in multiple group practice centres must comprise group practices whose work is related to a defined population, and these groups should be further divided into basic units whose work again is primarily related to a defined population.
(ii) The attitude of the staff should be such that all are aware of the importance of the personal doctor/patient or nurse/patient relationship.
(iii) The design of the premises should be such as to sustain the identity of the component group practices as we have defined them.

43. Draper and his colleagues have argued very cogently their concept of the Community Care Unit. In essence this is a group practice centre large enough to serve a population of at least 50,000 persons. A population of this size would, they maintain, make it possible to provide sufficient material to justify having some pathological and radiological services on the premises and also to provide sufficient referrals to justify having consultant out-patient sessions in the majority of the major specialties at the premises on a weekly or fortnightly basis. We believe that the duplication of expensive radiological and pathological equipment cannot be justified and that adequate access to these facilities at the district general hospital can be ensured by efficient transport of specimens and patients.

44. Considerable advantages might follow if the consultation between a consultant specialist and a general practitioner could take place in large group practice centres. This is the major argument in favour of the Community Care Unit. Community Care Units would need to have at least twenty doctors working from the premises. These doctors would need to be supported by nurses and secretarial staff in addition to other specialist workers. Consequently the number of people working in these units might be as many as 100 or more. We consider that the administrative organisation of such a large centre is not impossible, but it poses problems which can only be solved by experiment. These experiments would have to be carefully evaluated, and in this respect the Health Departments, together with the Royal College of General Practitioners and those medical schools with departments of general practice, would have a great part to play. It is essential that premises now in the planning stage be so designed that they can be enlarged in the future unless we are to find ourselves confined by the limitations of existing buildings. (We consider this matter in further detail in Chapter VI.)

The Work-load of a Group Practice

45. Throughout this chapter we have calculated the size of the population for which the group practice team could provide care upon the assumption that the average list size of a general practitioner is 2,500 and that a health visitor and a home nurse can each care for approximately 5,000 persons. It has often been suggested that one of the benefits of group practice would be that it would enable

a general practitioner to care for more people. The rationale behind this thinking is that there has been duplication of the work of the general practitioner, the health visitor and the home nurse; that if the general practitioner were closely supported by nursing and social work staff, then he could delegate work to them and that the secretarial help would free the doctor of much non-clinical work. We consider in Chapter III the role and work-load of the health visitor and the home nurse in detail. At this stage it is sufficient to say that all the evidence shows that:

(i) The case-load of both the health visitor and the home nurse is materially increased and tends to change in character when they work with the general practitioner.
(ii) Whilst the nurse and health visitor may relieve the general practitioner of some work, the health visitor also brings work to him by virtue of her function as a case finder.
(iii) The majority of general practitioners consider that the time they are able to give each patient at present is inadequate.

46. The work-load of the general practitioner has been studied in many different situations. It varies from area to area, from practice to practice and even from doctor to doctor. It must also be remembered that general practitioners fulfil other functions in the health service (see paragraph 27) and it is also envisaged that some general practitioners should take a more active role in the hospital in the future. For these reasons we think it is unlikely that a general practitioner would be able to look after very many more persons than the present average list size of 2,500 persons. We believe that group practice will allow redistribution of the work and therefore enable the doctor to spend more time with the individual patient. We consider that the advantages to be gained from group practice lie much more in the ability of the group to provide a higher quality of medical care in the community with consequent saving in the costs of the hospital services, and that if we can achieve this object it would justify economically the provision of a more generous staff/population ratio than exists at the moment.

CHAPTER III

THE NURSING STAFF IN GROUP PRACTICE

Background

47. The nursing services in the community have developed over a number of years in order to meet the requirements of the community and to fulfil particular needs as they became apparent. The result is that there are now a number of different kinds of nurse working in the community.

(i) The Health Visitor, whose work lies largely in the field of preventive medicine, health education and social problems of the family.

(ii) The Home Nurse, who undertakes the nursing care of patients in their own homes and the group practice centre, under the clinical direction of the general practitioner.

(iii) The Domiciliary Midwife, who provides continuing care throughout pregnancy, labour and the lying-in period.

(iv) The Practice Nurse, or Clinic Nurse, who works solely in the group practice centre.

(v) The Enrolled Nurse who is engaged on nursing duties under the supervision of the home nurse. The Enrolled Nurse undertakes the nursing care of patients in their own homes and in the group practice centre.

(vi) The Ancillary Nursing Help is a lay assistant who is responsible to and works under the supervision of the home nurse and health visitor. This ancillary worker undertakes simple nursing duties that are specifically allocated to her in the patient's home, or in the group practice centre.

(vii) The Home Nurse/Health Visitor (called in our report the Community Nurse). For many years, particularly in rural areas, there have been nurses who combine the role of the health visitor, the home nurse and sometimes of the domiciliary midwife as well.

(viii) The School Nurse. The majority of school nurses are also health visitors and are employed on nursing duties in the School Health Service. In special circumstances, described in the School Health Service Regulations, 1959, a State Registered Nurse may be graded as a school nurse. The function of the School Nursing Service is to provide services for both the child and the school, and to maintain a health link between the school and the home. The health visitor/school nurse maintains continuity of supervision by making regular and frequent visits to the school, and in consultation with the teacher is able to identify children who need medical examination and to give particular attention to the detection of certain defects, especially early defects of vision and hearing, and abnormalities of behaviour.

48. The National Health Service Act 1946 made it a duty for local health authorities to provide a home nursing and domiciliary midwifery service to meet the needs of their citizens, and to make provision in their areas for health visitors to

visit at home expectant and nursing mothers and to advise on measures necessary to prevent infection and on the care of young children. There was a rapid expansion in the work of the home nurse in both quantity and character and the work of the health visitor began to extend to take in other members of the family—the school child, the tuberculous, the chronic sick, the handicapped and the aged. A large measure of administrative cohesion was thus achieved but in some areas little functional unification occurred. The home nurse, health visitor and domiciliary midwife continued to work in isolation, rarely meeting each other and having little contact with the general practitioner. Communication was consequently difficult and in some instances led to unnecessary duplication of work.

49. Schemes of attachment of nurses to the practices of doctors have helped to solve some of the problems arising from the previous isolation of the nurses and the doctors. At the same time, however, these schemes have contributed to changes in the pattern of work of the nurses and of the general practitioner. This has resulted in some confusion as to the future role of the various nursing personnel, and this uncertainty was apparent in the written and oral evidence given to us. It is accepted that attachment is essentially a partnership of nurses with general practitioners. If we are to be able to place a greater emphasis upon the quality and content of our medical and health care outside the hospital and to integrate such care with the hospital service, we think it is necessary to take an entirely fresh look at the needs for community nursing services and especially in group practice.

The Nursing Needs of Group Practice

50. We believe that the nursing needs of group practice correspond broadly with the nursing requirements of the community as a whole.

51. The functions of the health visitor and home nurse need to be provided in the setting of the home and group practice centres. There will, we think, be an increasing need for this type of work because of changes in morbidity patterns and as techniques in medicine advance. Furthermore, the success of early discharge and day surgery schemes will depend upon a high quality service of this nature.

52. Work studies undertaken by local authorities into the content and method of work of nurses in the community have helped to assess the extent to which more use could be made of state enrolled nurses and ancillary nursing help. Information obtained from the Department has shown the increasing use made of state enrolled nurses and ancillary nursing help. Some local health authorities have been very slow to implement the recommendations of the Sub-Committee of the Standing Nursing Advisory Committee (1964) (21) in this respect, despite repeated approval of this principle by the Health Departments. The state enrolled nurse is now an accepted member of the community nursing service and, increasingly, certain tasks, such as bathing, dressing and undressing of patients, are delegated to ancillary nursing staff who are responsible to the home nurse or health visitor. If nursing units in the community are established, as we recommend in Chapter XI, then we think that the nurses of a group practice may have a part to play in the work of these units.

53. It is likely that the need for preventive nursing work will increase in the future for persons of all ages within the population. All those working in group practice should develop the opportunity to give advice on health education. It will be necessary to set aside special sessions within group practice for such work as

child health clinics, immunisation, family planning and pre-symptomatic screening programmes. The value of the work done will be greatly enhanced by the use of an adequate records system in group practice and with the help of the community physician and his department in co-ordinating the activities of the group practices within an area.

54. We have stated elsewhere that we do not believe that medical care can be separated from social care. Furthermore it seems to us self-evident that most of the problems which occur in the course of almost any illness are better dealt with by one of the health team immediately concerned with the patient. Where social workers have been attached to group practice it has been found that there need be no unnecessary overlap of functions and that social workers deal only with the social problems which require their special skills.

55. The Peel Report (11) has recommended that the hospital and domiciliary midwifery services be integrated and that, with few exceptions, all women should be delivered in hospital, although many will only need to stay there for a short time. In particular, the Report stated that in these latter cases there should not be a rigid time in the lying-in period when the midwife's functions cease and the health visitor's role begins, but that this should depend upon the needs of the mother and her baby. There would be advantages if the care of the mother and baby discharged early in the post-natal period were subsequently provided by her own doctor and the nurses of the group practice. Ante-natal care will remain a very important function of the group practice team of which the hospital midwife should be a member.

56. There is a considerable amount of work undertaken at present by the general practitioner which could be delegated to suitably trained nurses, and similarly some work could be delegated by highly trained nurses to less highly trained nurses or even to suitably trained lay staff. The doctor's essential skill is in making clinical decisions. Many tasks which do not require a clinical decision can therefore be delegated. State registered and state enrolled nurses have always undertaken certain functions up to the point where a decision has to be made. Examples of these functions are the taking of measurements such as temperature and blood pressure, the collection of pathological specimens, simple laboratory tests such as urinalysis and haemoglobin estimation, and certain therapeutic procedures such as injections and cautery. In some areas state registered nurses have received in-service education so that they take venous blood and undertake diagnostic procedures such as electrocardiography, lung function tests and audiometry. It is important that each member of the team—the doctor, nurse, health visitor, midwife, state enrolled nurse and ancillary nursing help—is used to the highest level of skill.

57. We know of instances where a nurse acts on behalf of a doctor in situations in which a decision is required. Examples of this type of work are when a nurse is used to screen patients before they see a doctor, and undertakes follow-up visits or consultations. There is considerable potential for the development of this type of work so making the best use of medical and nursing manpower both in terms of economy and efficiency. However, great care must be taken to ensure that the nurse does not form a barrier between the doctor and his patient. Pilot schemes, both planned and now in progress, must be carefully evaluated. In areas where such a pattern of work has not yet evolved it is important that nurses should receive specific training if they are to undertake such functions.

The Type of Nurses Needed in Group Practice

58. Before considering the type of nurses who will be needed to perform the functions outlined in the preceding paragraphs we think it is necessary to stress certain pre-requisites that will need to be satisfied, and certain facts that must be recognised if the group practice team is to work as a functional unit.

(i) The size of the team must be reduced to the minimum compatible with providing the range of services needed.
(ii) There will be an increasing demand for preventive measures of all sorts.
(iii) The concept of the district general hospital and the present trend for medical care to take the form of short intensive treatment in hospital and a more extended care in the patient's own home will place increasing demands upon the nursing services in the community, calling for an increasingly high quality and a wider range of nursing skills.
(iv) Economic use must be made of both medical and nursing skills.

59. The group practice and nursing personnel are responsible for providing the whole range of personal care services for the patient and family. The simplest solution would be to have one trained multi-purpose nurse who received post-basic training to enable her to provide total nursing care supported by state enrolled nurses and ancillary nursing help to whom she could delegate appropriate tasks. Each doctor would, we think, require one nurse of this sort to work with him. Within a group practice the nurses would be able to provide cover for one another. Nurses of this type exist in those areas, mainly rural, where the roles of the health visitor and home nurse and even midwife are encompassed by a single nurse.

60. The attraction of such a system is obvious. Preventive medical care is not segregated from curative care. Arrangements of this kind would seem to simplify communication between doctors and nurses. The care of the individual patient is provided by fewer persons and consequently there is greater continuity.

61. The disadvantages of this system were put to us forcefully by many of our witnesses. There are not enough nurses to provide such a service; nurses prefer to specialise and some are more temperamentally suited to the demands of curative medicine, whilst others have the personality for and are attracted to preventive work. The most important objection was that the demands of curative medicine would take precedence over and detract from the quality and scope of the preventive work. Out of necessity the community nurse has had to be employed in some places and this system might well be adopted more widely if it were felt to be the best. There is a clear need for further experiment in this field.

62. A second solution would be to have a nurse who is trained to provide all the requirements of group practice with the exception of preventive work and health education. This latter function could be undertaken by fewer nurses trained more specifically for this role. With this method it would be probable that each doctor within a group practice would require the services of one state registered nurse supported by a state enrolled nurse and ancillary nursing help and that preventive work and health education for the group as a whole could be undertaken by one or two specialist nurses. Whilst this method would have the advantage of limiting the size of the basic unit, the nurse specialising in preventive care would tend to become isolated from the individual patients and would need to relate her work

to a number of doctors. Furthermore, preventive medical care would be quite rigidly separated from curative medicine.

63. A third solution is essentially a compromise between the two extremes outlined in the preceding paragraphs and is one commonly found today where nursing personnel have been attached to group practices. The present health visitor, home nurse and enrolled nurse work as a nursing team with ancillary nursing help in order to supply the total nursing needs of the group practice. A ratio of one health visitor, home nurse and enrolled nurse to every two doctors in a group accords with the numbers available at the present time. In addition to their basic training each should have suitable post-basic training to enable them to perform their individual roles. Such training should prepare them to work as a team, each nurse understanding the skills of the other. Whilst there would be a need to identify the role of each, this should not be carried to the stage at which one nurse would be unable to provide temporary cover for the other.

64. We have insufficient evidence to recommend the adoption of either of the first two methods of providing nursing care. Further carefully evaluated experiments of both methods must, however, be undertaken in the setting of group practice and a unified health service. Moreover, it is obvious that the nursing service in the community can only evolve from the existing pattern of service. For these reasons we recommend that the nursing service of a group practice will be best supplied by the present health visitor, home nurse and enrolled nurse, who should be attached to the individual doctors within the group practice and supported by ancillary nursing help (Appendix F, Table 6).

65. There are some nursing functions needed in the community other than those connected directly with group practice. The community physician will have an important role to play in the organisation of these services. In his capacity as an epidemiologist he will also require the services of the same nurses to enable him to carry out his function. It should not be necessary to develop a separate type of nurse to undertake this work.

The Organisation of Nurses in the Community

66. We agree with the recommendations of the Report of the Working Party on Management Structure in the Local Authority Nursing Services (Jan 1970). We accept that the nursing services in the community need to be co-ordinated and directed by a chief nursing officer. The administration of the community nursing services involves considerable management responsibilities and the chief nursing officer and her nursing officers have a role to play in the deployment of nurses amongst group practice.

67. We state elsewhere that the detailed organisation of a group practice should be the concern of the doctors within the group. Likewise, the detailed organisation of the nurses' work within a group should be the concern of the nurses in consultation with the doctors. A significant feature of successful attachment schemes has been the way in which the nurses have identified themselves with and have developed a loyalty to the practice. We welcome this as being the kind of attitude that we think should exist in group practice. It is important that the nurses within each group practice can have the counsel and support of first-line managers as recommended in the Working Party Report on Management

Structure in the Local Authority Nursing Services (22). This nursing officer will be the senior nurse of the group practice and will be responsible both to the doctors and the chief nursing officer in the community.

68. The organisation both at the area level and within the group practice will need to be flexible and capable of adaptation to meet the needs which will vary from time to time and in different localities. No distinction should be maintained between the practice nurse, as employed today, and local authority nurses working within the group practice. We recognise that a separate practice nurse has suited some practices and nurses but it should not be continued within a unified health service.

69. The nurses in group practice require accommodation which should include a separate room or rooms in which they can work when they are not seeing patients. Nurses will need to be supported by the secretarial staff of the group practice. It is essential that the nurses are provided with adequate transport facilities.

The Future Training of Nurses for Group Practice

70. In their evidence to us the General Nursing Council stated that the basic training will in the future give the student nurse some awareness of nursing outside the hospital. We welcome this. The training of the health visitor, the home nurse and enrolled nurse should be adjusted where necessary so that all the nursing needs of the group practice that we have outlined are covered, without unnecessary duplication. We welcome the setting up of the Asa Briggs Committee "to review the role of the nurse and the midwife in hospital and the community and the education and training required for that role". We recommend that both the training of the health visitor and home nurse should include training in selected group practices (see Chapter XII). It will be essential to arrange for suitable courses of re-training for married nurses who return to work as their families grow up.

The Need for an Increase in the Future Establishment of the Nursing Services in Group Practice

71. It is clear that with the growing costs of institutional care and treatment the demands of the community services will increase with a consequential need for substantial expansion in the numbers of nurses in the community. Our recommendations will also require a further increase in nursing establishment if the proper and best use is to be made of available nurse manpower. There appears to be little difficulty in attracting nurses to work in the community. Some of those who gave evidence to us were concerned that a substantial increase in the establishment of the community nursing services would be reflected by even greater staffing problems for the hospital service. This incorrectly assumes that competition for recruits will necessarily be from the same field. The evidence that we have received suggests that the majority of those nurses who work in the community nursing services would not wish to work in a hospital at all. The work is particularly attractive to the married nurse and, with proper organisation, considerable use can and should be made of part-time nurses.

CHAPTER IV

SOCIAL WORK AND GROUP PRACTICE

72. We mentioned in paragraph 17 that we do not consider that the social aspects of medicine can be separated from the clinical. The Royal Commission on Medical Education (8) took the same view and quoted the Goodenough Committee (23) which said that "Teaching in the social aspects of medicine should be integrated with the clinical work of the student during the undergraduate course and intern year". The report also said "There is no single way of achieving this aim. Sociologists, social workers, hospital clinicians, general practitioners, social administrators, social medicine and public health staff and others, will all have integrative contributions to make at different stages in the curriculum". Psychiatrists and paediatricians in particular, are convinced of the inadvisability of separating the health and social services.

73. If team work between social workers and medical workers is so important in education, it is equally vital in general practice. The Institute of Medical Social Workers stressed the importance of team work in their evidence to us and said "Group practice reaches out into the community to serve people with problems of physical and mental ill-health. In so doing, they also uncover problems of social ill-functioning that would not be brought to the notice of other personal health services. We envisage group practice being an important spearhead into the community for the detection of problems of social ill-functioning." The necessity for close co-operation and team work between social workers, health visitors and general practitioners was recognised in the Seebohm Report (14) (paragraph 690 and onwards). In paragraph 700 the Report recommended the attachment of social workers to group practices.

74. The Seebohm report, in paragraph 589, recommended the experiment of the siting of area offices of the Social Services Department in association with health centres. The inclusion of all types of social work within a health centre would lead to a very large professional group, and the use of the centre by large numbers of people many of whose problems would have no direct medical association. Whilst it would be logical to site an area office of the Social Services Department close to a health centre we do not favour their combination in one building. The second Green Paper (2A) proposed in paragraph 46 that social workers should be made available to serve the community health services centred on the general practitioner. The incorporation of a social worker in the group practice team would provide the necessary link, retaining those problems which have a major medical content and handing on the rest to other social workers in the nearby area office of the Social Services Department.

75. Although the Seebohm Report listed many of the advantages that would follow if a social worker were to work in a team of general practitioners, it pointed out that general practice and general practitioners are not all yet ready for such a programme (paragraph 699) and that their training is inadequate in this respect

(paragraphs 694–696). We agree with the criticisms in the Seebohm Report concerning the inadequate training of doctors in respect of the social aspects of medical care, both in the undergraduate and the postgraduate phases. The implementation of the recommendations of the Royal Commission on Medical Education would go a long way towards correcting these defects. On the other hand the Standing Conference of Organisations of Social Workers also felt that the present training of social workers did not fully equip them for work in group practice. We think that it would be unwise to reject the idea of a social worker as a member of a group practice on the grounds that the training of general practitioners and social workers is at present inadequate. It makes more sense to point out the defects in the education of doctors and social workers that exist today and to assume, as we have done, that adequate training for both will exist in the future. A social case worker has an important role to play in the group practice team but at the moment there are very few social workers who are trained to undertake the work we have in mind.

76. The present training of social workers for the health and welfare services is varied. Many take a two year course of integrated theory and practical training leading to a certificate in social work. Others are university-trained as psychiatric social workers, medical social workers or family case workers, usually taking a degree or diploma in social science followed by a professional course of at least one year. Some take a two year course following degrees in other subjects, or a composite four year course including a degree and professional training. Students on professional courses do practical training in hospitals, local authority social service departments and voluntary organisations.

77. Within group practice we see the work of the professionally trained social worker as:

(i) The assessment of psycho-social problems.
(ii) Case work with individuals or groups.
(iii) Liaison with other agencies.

We agree with the concept of broadly based, non-specialised generic training for social workers (Seebohm Report, Chapter 18). However, just as newly qualified doctors require postgraduate training and experience to fit them for work as general practitioners, so does the newly qualified social worker in order to fulfil the exacting and highly professional role that we envisage within the group practice team. A major part of this training must include experience of work with the mentally and physically ill, both in and out of hospital, family casework in the community, and work to give some knowledge of the prevalence, incidence and management of diseases in the community. In these respects, teaching in group practice should provide an excellent training situation (see Chapter XII).

The Role of the Social Worker in Group Practice

78. The importance of a team approach to social and medical problems becomes immediately apparent when one considers the role of a social worker in the community. Social work in some form is involved in much of the work of the general practitioner. In acute illness simple explanation and support may be required, based on medical knowledge and experience and involving a sympathetic ear, together with the mobilisation of such physical support as is needed. In chronic illness more continuous support and guidance may be required and additional

problems of housing, employment and finance may arise. Many patients seen in general practice are suffering from non-organic illness. Some are suffering from psychoses or are sufficiently disturbed to require hospital treatment. Others are suffering from stress which can be simply resolved by explanation, advice and the passage of time. There is, however, a significant group who require case work in depth and over a long period of time and who are best handled within the group practice (see paragraph 80). At present there is a shortage of trained social workers with the appropriate skills to meet this need.

79. The advice, support, explanation and mobilisation of physical resources required in both acute and chronic illness can often be supplied by the health visitor with her background of medical knowledge and nursing experience and the relationship which she has with the families in the community. The social content of her work will be eased if a social worker is present but the knowledge that she and the general practitioners have of the families under their care can be extremely valuable when case work is subsequently required, and this in turn may bring to light other problems within the family which would again come within her sphere. In some cases of chronic disability, for example in the case of a mentally or physically handicapped child, a social worker may also be involved and close liaison between all those concerned is essential.

80. Though the general practitioner of the future will have more training in the behavioural sciences he will not have the time to undertake much case work. We have evidence from general practitioners and social workers (Forman and Fairbairn at Barnstaple (24), Faulkner, Goldberg, Speak and Neill in London (25), Page and Gough at Coventry (26)) that a social worker of suitable training and experience, working as a member of the group practice team, can best supply this need. Many patients require case work, medical assessment and medical care. Emotion disturbances may be present as, or be involved with, physical disease, and likewise physical disease may present as an emotional disturbance. It therefore seems essential that the social worker should be an equal member of the community care team. Only in this way can a team approach to the patient's problems be encouraged and the necessary communication between doctor, social worker and nurses be obtained. Social workers in the group practice team would be ideally placed for the convenience of the community and also in the best position to undertake preventive and case-finding work.

81. In the preceding paragraphs we have attempted to define the type of social work which is required in group practice. There have been few attempts to quantify this or to assess the number of such social workers who will be needed. Further work of this sort is urgently required.

82. The Home Help Service provides physical support in the home at the present time primarily for those who are ill or infirm and are therefore already under some degree of medical supervision. The home help is a valuable source of information about changes in the patient's condition. Although a part of the social services, close liaison between the home helps and the group practice cannot fail to be beneficial to the overall care of the patient and is essential where early discharge schemes are in operation. We therefore think that home helps should be attached to the group practice team.

83. There is a need to bring voluntary agencies into closer contact with the community care team. Some, such as the WRVS, are centrally organised, while

others are in small groups based on a local church or community centre. A small liaison committee, embracing all such organisations within the area served by the group practice or health centre, might be sponsored to form a link with group practice. A health visitor or social worker could well undertake this. Over a wider area, these efforts could be co-ordinated by a paid organiser provided by the district committee.

CHAPTER V

THE SECRETARIAL STAFF OF GROUP PRACTICE

84. In this chapter we deal with the clerical, secretarial and administrative staff of a group practice and we use the term "secretarial staff" to embrace all those in a group practice who are not doctors, nurses, or social workers.

85. To make the best use of their professional training general practitioners and the professional colleagues working with them in group practice should have sufficient staff to whom they can delegate as much of the clerical work as is possible. Enough staff is needed to cover sickness, off-duty periods, holidays and out-of-hours work (e.g. afternoon consultations extending beyond the normal working hours). Delegation of work to secretarial staff is a comparatively recent development in general practice, and the present levels of staffing may be found inadequate in the future. In this connection we believe that secretarial assistance would increase the efficiency of the health visitor, nurse or social worker in the group practice team.

86. All the professional staff of a group practice team will be serving a common population and consequently we think they should therefore share the same secretarial staff. This will have a potent effect in encouraging the development of a team approach to their work. It was stressed by the majority of organisations representing general practitioners and by individual general practitioners, who gave evidence to us, that the secretarial staff should be selected by the doctors in a group practice. We agree that the doctors should play a major part in the selection because we regard each group practice as a team providing an essentially personal service, in which compatibility of personalities will be an important consideration. Furthermore, this method of selection places the responsibility for the success of such appointments upon the group practice itself.

87. In considering what secretarial help is required, and how staff should be trained, we have looked at the overall secretarial needs of a group practice and can identify five different functions. These need not necessarily be fulfilled by different people.

(i) The first type of service is that which involves contact with patients. It includes the reception of patients, the management of their movement in the building, the interpretation and management of patients' enquiries at the reception desk, making appointments for consultations and recording requests for home visits. We feel this service should also include the reception of similar enquiries and requests by telephone because this is an important part of the reception service in general practice. We discuss this further in paragraph 93. This type of service calls for courtesy, patience, good humour and understanding, as well as efficiency and reliability. It does not, however, necessarily require a nurse's training or typing ability.

(ii) The second type of service is that associated with the handling of records,

and is essentially clerical in nature. It includes the extraction and filing of record cards and their day-to-day maintenance; the registration of new patients; the maintenance of practice registers such as age/sex and morbidity registers and the clerical work associated with research projects. It is too early to predict the effect of the computer on general practice records but, if this develops, the requirements of data handling will fall into this category. Shorthand and typing are not essential requirements in this type of service.

(iii) The third type of service is medical typing and shorthand, the use of office equipment, such as dictating machines, duplicators, or photo-copying machines, and dealing with the correspondence and allied work for all the professional members of the group practice.

(iv) The fourth type of service is in the field of technical procedures related to the clinical work of the practice which are normally undertaken in hospitals by laboratory technicians. This includes urinalysis, on-the-spot erythrocyte sedimentation rate and haemoglobin estimations; the collection of specimens for the laboratory, such as swabs, midstream urine specimens, and venous blood; pregnancy testing and electro-cardiography. We think the call for such procedures, of which the majority will necessarily be performed within the practice premises, may become greater in number and type. It will be increasingly important to provide for such services in order to make the best use of the skills of the doctor or nurse.

(v) The fifth requirement is for leadership and co-ordination. This requires a person who will act as the senior member of the secretarial staff; organise the work of the office in conjunction with the professional staff; act as spokesman for the secretarial staff as a whole; manage staff salaries and manage the practice acounts in association with the practice.

88. The evidence we have heard demonstrates the wide variety of secretarial staff who cover these functions at the present time. In this developing phase of group practice organisation we feel that it is not only inevitable, but desirable, that different methods are tried in order to evaluate and establish the most effective patterns.

89. There is some conflict in deciding upon the composition of the secretarial staff for group practice. On the one hand, each of the service functions described above can be reflected by the appointment of differently trained personnel, e.g. receptionists, records clerks, typists and technicians, who together form a composite team. This ensures the appropriate training for the work performed. The rigid application of this principle could lead to inflation of the number of persons forming the group practice team, the generation of unnecessary communication problems, and loss of flexibility in holiday and sickness cover. The alternative method of employing people capable of carrying out several functions is more appropriate to a small team offering a personal service, and is likely to reduce the size of, and therefore to improve the communication within, the team and prove more flexible in practice. Our recommendations for the composition of the secretarial staff for a group practice recognise this, but accept some compromise between the two methods.

90. Considerable confusion exists at present because of the use of various terms for the same function. For clarity we use five terms only, each indicating the main

function which is performed, viz. receptionist, medical typist, records clerk, practice manager and technician. Subject to the comments which we have made above, we suggest that each type of service described in paragraph 87 can best be provided by:

(i) Receptionists to whom are allotted all the duties involving patient contact, whether contact is made in person or by telephone, and the day-to-day management of records, appointment systems and visiting lists, all of which relate naturally to the service given to individual patients.

(ii) Records clerks whose sole function will be the maintenance of records. At the present time, however, we feel that this function can be undertaken by the receptionists, giving greater flexibility for cover in sickness and holidays and perhaps greater motivation and work satisfaction, since they know the patients concerned. Nevertheless, we see a limited function for records clerks where age/sex and morbidity registers are maintained, and to deal with records overall and especially the management of their flow to and from the Executive Council. With the development of computer-based records there will be a greater need for records clerks in the future.

(iii) Medical typists who carry out typing and allied office work in an office set apart from the reception area.

(iv) Technicians. The technical procedures related to the clinical work of the practice are at present commonly performed by the doctors themselves, by the practice nurse or attached nurses, or in some instances by secretarial staff. While we consider it advantageous to free professional staff from such technical procedures, it is doubtful whether the volume of work provided by a group practice would justify the appointment of a technician. In multiple group practices, a technician could be justified, but we think that this might present problems of communication, supervision and isolation and prove an extravagant method. The evidence we have heard suggests that such procedures in the main are being undertaken by nurses and we think this should continue. On the other hand, there is evidence from Holland (17) and elsewhere that receptionist training can be extended to cover some technical procedures, for instance, urinalysis, erythrocyte sedimentation rate and electrocardiography. This appears to us to be a way of relieving the pressure on nurses' and doctors' time, and bearing in mind that these procedures do not call essentially for a nurse's training, we recommend that experiments in extending receptionist training to cover this area be conducted.

(v) Practice Manager. We recommend that the functions of practice manager should be a part-time function of the senior receptionist within a group practice, but in multiple group practices and in health centres accommodating more than one group practice, we think there should be a separate post of practice manager, filled by someone with greater experience. We think that it would be advantageous if such a person had trained and served as a receptionist in group practice and if the post is seen as the senior appointment in the secretarial service.

91. The role of the receptionist in general practice needs special attention. This role, whether in single-handed or in group practice, is more exacting and carries

greater responsibilities than are usually implied by the term "receptionist" in other occupations. Though much of the work is routine, most of it is given as a personal service to individual patients, with all the demands that this entails. While dealing with a large number of items of service in a limited time, the receptionist has yet to give full attention when required to patients who may be anxious, confused, aggressive, inarticulate, or simply in a hurry, and to interpret both their difficulties and their needs. Her success or failure in this task may have a lasting effect on the value of the relationship subsequently established between the patient, doctor, and nurse. She must be capable of relieving the professional staff of routine enquiries, so that clinical work can go forward, and at the same time guard against setting up a barrier between patient and doctor. Indeed, she must act as the patient's guide in providing appropriate contact with the professional staff, and she must be constantly on the watch for serious or urgent situations demanding immediate attention. We draw attention to these facts because of their importance in the selection and training of receptionists and to underline the difference between this service and purely clerical work.

92. We have noted the evidence given to us concerning the value of a "personal secretary" working with one doctor in single-handed practice, and we think there is substance in the suggestion that this function could be fulfilled by "secretary/receptionists" trained to cover both the reception and clerical and office work. Receptionists so trained and attached to the basic units we have suggested in Chapter II, could supply all the secretarial needs of each basic unit. This would have the effect of reducing the total number of people concerned with each patient, and we think it would make for efficiency, confidentiality and easy communication. We recommend further research into the effects of such a system on the standards of care given and the cost of providing it.

93. We have made no mention of telephonists in discussing the secretarial staff. The incoming telephone calls to the group practice, which unlike incoming calls to a hospital are predominantly directly from patients, should be handled by suitably trained reception staff. The delegation of this work to the sort of persons likely to be employed as telephonists would place too much responsibility on the latter. We recommend, therefore, a telephone system which puts patients directly into contact with the receptionists of the practice, who can then transfer calls direct to a doctor, if required, and that patients should not have to deal with any third party in addition. In the larger multiple group practice, one receptionist may need to be on continuous switch-board duty.

94. Although the method of payment of the secretarial staff is not strictly within our remit, we feel that we must make some comment upon it, because it could influence the development of satisfactory group practice. We recommend that the Health Departments and the representatives of the profession should maintain a continuous watch upon this situation, in order to ensure that doctors are not penalised financially by providing themselves and other members of the group practice team with adequate secretarial help. It is important to recognise that many of the persons who occupy secretarial posts in group practice work part-time. There are advantages in this arrangement, because it allows greater flexibility and, more important, makes it possible to attract the more mature type of person with suitable experience and ability.

95. We recommend that the provision of courses for receptionists, as distinct from medical secretaries, should be encouraged. An increasing number of Tech-

nical Colleges are providing courses based upon the syllabus of the Association of Medical Secretaries. We would draw particular attention to that part of the syllabus which stresses the need for in-service training within specially selected group practices of varying types and in differing environments.

96. For the most part, any secretarial work which may be required by the professional staff of the community physician, or visiting staff from the hospital, should be undertaken by the group practice secretarial staff.

CHAPTER VI

THE PREMISES FOR GROUP PRACTICE

The Present Position

97. Broadly speaking general practitioners in group practice work at the moment from three types of premises:

(i) Health centres which are financed and built by the local health authority under Section 21 of the National Health Service Act, 1946.

When loan sanction is required, as it is in the majority of cases, the Health Departments must approve the plans and costings. All general practitioners in the locality of the proposed health centre are invited by the Executive Council to say whether they wish to practise from the centre. There are no statutory restrictions on its use as a branch surgery, but we welcome the fact that a diminishing proportion of practitioners are using health centres in that way.

(ii) Group practice premises leased by the general practitioners from a private developer, a public development corporation (as in new towns), or the local authority (as in urban development).

In the last two cases if loan sanction is required it had in the past to be sought from the Department of the Environment who were only prepared to approve such projects in certain circumstances. (Procedures operative from April, 1971, will mean that local authorities need not seek loan sanction from central government for this type of development).

(iii) Group practice premises owned by the practitioners themselves and financed privately or through loans from the General Practice Finance Corporation.

The local health authority may rent accommodation from the practitioners for the provision of their own services.

Reimbursements of rent and rates in respect of practice premises are made by the Executive Council in accordance with the scheme of remuneration for general medical practitioners, but should the District Valuer's assessment of the current market rent be less than the amount incurred by the doctors, except in health centres, then the general practitioners must themselves bear the difference. We were glad to learn that the Health Departments and the representatives of the profession are at present discussing an alternative basis for payments by Executive Councils in respect of new separate purpose-built premises. The doctors bear the whole of the cost of services such as heating, lighting, and cleaning or, in the case of health centres, the equivalent charge made by the local health authority.

98. It is very costly to provide premises which are efficient and well-equipped, with the emphasis on the team approach, and yet retain the atmosphere of a

close doctor/patient relationship. We have seen many fine examples of well-designed group practice premises, furnished and equipped to a very high standard, and fully justifying the pride of the doctors owning and working in them. Rising building costs and the scarcity and prohibitive price of suitable sites in urban areas may well deter practitioners who are contemplating privately-owned premises, designed to accommodate a modern health team, for in addition to the repayment of capital (perhaps £5,000 to £6,000 per doctor over 25 years) interest rates are high (currently 10 per cent from the General Practice Finance Corporation). Moreover, in spite of arguments that property is a good investment, the young doctor may well think twice before saddling himself with a mortgage for practice premises in addition to one for his house and, if the retiring partner's share is required to be purchased, this may well lead to a partnership vacancy remaining unfilled. Were it not for the high cost of land and buildings, many general practitioners would at present prefer to work in premises which they own themselves.

99. The increasing popularity of health centres among practitioners is mainly due to the advantages doctors see for their patients when they practise in a health team from these buildings, but is also partly due to the difficulties outlined in the previous paragraph.

100. Although there has been an increasing desire on the part of many doctors to practise from health centres, we were told that a feeling of insecurity is engendered by the necessity for practitioners to become sub-tenants of their Executive Council. Although this argument was very forcefully made to us we were impressed by the fact that it was seldom, if ever, raised by doctors actually practising in a health centre. Nevertheless the clearing up of any misunderstanding would increase the goodwill towards the general acceptance of health centres. Health centres should be sufficiently attractive in form and conditions of lease to attract general practitioners.

101. As a general rule group practice premises have not so far been designed to offer as comprehensive a range of services as do health centres serving a comparable population, especially in regard to some preventive and community activities in which the general practitioners are becoming increasingly involved. We have seen many group practice premises where the standards of accommodation, the equipment, and the degree of integration with the local health authority services compared very favourably with that in some health centres, and the General Practice Finance Corporation has made it possible for general practitioners, who are willing to do so, to provide group practice premises appropriately planned to accommodate the full range of preventive services for their area. We feel that, at the present, there is something to be gained by having both types of premises, subject to the approval of the proper health planning authority.

102. At the present rate of building it is estimated that only about 12.5 per cent of the general practitioners in the country will be able to practise from health centres by 1975. It will be necessary to give every encouragement and help to those general practitioners who are providing an efficient service from group practice premises, to make it possible for them to provide a full range of services. If these practitioners later move into health centres it should be recognised that they may suffer a capital loss, which could be proportional to the quality of the service that they had been providing. Equitable arrangements should we think be made

to ensure that such capital losses are made good if they transfer to health centres. What we have to say in the remainder of this chapter is applicable both to health centres and group practice premises.

The Siting of Health Centres and Group Practice Premises—Area Health Planning

103. We have stated elsewhere that we think that in future primary medical care in the community will be based upon larger, and therefore fewer units. These must, therefore, be strategically sited in relation to public transport and the hospital services. Other local considerations will also influence the requirements if efficient medical care and the convenience of the patients are to be evenly matched. In our opinion this demands judicious area planning if we are to avoid haphazard development. Planning should be by consultation rather than compulsion. Flexibility and speed of construction should be ensured by laying down well-defined lines of consultation locally and there should be the minimum of limitations determined centrally by the Health Departments. We believe that privately financed group practice premises should be considered by the authority responsible for health service planning as well as those that are built out of public funds, so that private development may be compatible with the overall plans for an area. This could be achieved by consultation at the time when application is made for a loan from the Finance Corporation and when planning permission is sought from the Local Authority.

The Design of Premises

104. The increasing cost of building enforces some uniformity of construction, but within this limitation the maximum possible flexibility is essential and it must be borne in mind that the premises will be used not only by the doctors initially occupying them but by succeeding generations as well. The design of the premises for group practice should be determined by a detailed consideration of the functions for which the building is to be provided. We have seen the booklet "Buildings for General Medical Practice" (28), and the "Design Guide for Health Centres" (29) produced by the Department of Health. We were attracted by the idea of the general adoption of unit structures which might be joined together as required in order to reduce building costs, and we recommend that this aspect be further explored. Although a great deal of attention is being paid to design, we were disappointed to see quite new health centres constructed on very traditional lines and showing no evidence of the thorough study of user requirements which is so necessary as a prelude to the design brief. We feel it necessary to cite some specific examples:

(i) Health centres in which the design still creates a separation between the general practitioner and the local health authority staff.
(ii) Examination rooms so designed that one can only examine a patient from the left side.
(iii) Records and reception areas which are too small.
(iv) Treatment rooms which are too far from the consulting suites.
(v) Play areas for children which are not visible from the waiting area, with the result that receptionists have to search for a parent.

Further attention needs to be given to the briefing of architects responsible for the design of health centres by those who are fully familiar with the uses to which the centre will be put. There is a need for thorough and continuing study of user

requirements which we recommend should be accompanied by an on-going review of the functions at existing centres so that lessons may be learnt for the future.

105. It is not possible to predict the future requirements of a health centre with any precision. In Appendix G we list the activities for which accommodation may be required at present together with a schedule of accommodation based upon these activities. Future advances in medicine together with a more rational approach to the use of the health and social services, will inevitably demand changes in functions, and therefore the design of health centres. We believe that it will, for instance, be necessary to provide accommodation for visiting hospital specialists and peripheral nursing units in centres (see Chapter XI). Therefore we recommend that the design and construction should allow for the utmost adaptability. We must not in the future be constrained by the bricks and mortar we erect now. The need for adaptability in design is especially important because, in order to foster personal care of patients, the design of a health centre should help to maintain the identity of the basic unit and of the group practice. We suggest that experiments in design should be undertaken with the following criteria in mind:

(i) Each group practice, which will include doctors, nurses and health visitors, should have a separately functioning section of the health centre, including their own sub-waiting area, and offices. This could be modified to begin with for single-handed or small practices working within a centre.
(ii) In multiple group practice centres this pattern can be duplicated and joint use be made of other accommodation, such as health education areas, specialist consulting suites, minor surgery accommodation, etc.
(iii) Provision may need to be made for teaching in all or any of the disciplines represented in the centre (see paragraph 220).
(iv) Adequate telephone arrangements, both internal and external, must be made.

106. In Appendix G we have deliberately made no provision for the sale of welfare foods because we do not think a health centre is the proper place for this activity. The provision of such a service tends to cause disorganisation in the smooth running of a health centre and it would seem to us more appropriate for this function to be undertaken elsewhere.

107. It is most important that health centres in addition to being functionally efficient, should be pleasant places in which to work, and should be attractive to patients who have to come to them. This can have a potent effect upon the morale of the staff and the attitude of the patients.

108. We saw many examples of consulting room accommodation being shared between doctors, or between doctors and nurses. Whilst accommodation should be economically used, we think that the individual doctor will spend more and more of his time in his centre in the future and so will need a room in which he can work even when he is not seeing patients. For these reasons we recommend that provision should be made for each doctor to have his own consulting room. For similar reasons the nurses and social workers will also need appropriate accommodation. Some additional interview or recovery rooms should be included which could be used by any member of the team.

The Size of Premises and the Problems of Special Areas

109. Similar considerations to those that we have discussed in the siting and design of premises apply when considering the size of group practice centres. This will depend upon a close analysis of the local geographic and social characteristics of the population, and upon the overall planning of the health and social services for a particular area. Whilst we believe that the future will see the development of many more multi-group practice centres, there is little in the nature of experience upon which we can base recommendations. We received much evidence that the aversion of many doctors to the concept of large health centres stems from a fear of damaging the continuing doctor/patient relationship upon which so much depends in the provision of high quality general practice; and to the fears of loss of professional freedom and of bureaucratic control. These fears must be met by appropriate safeguards in design and administration. It is also important that any group practice centre, publicly financed or otherwise, should be sited and designed so that it is capable of subsequent expansion.

110. Rural areas pose an opposite problem. In many instances the population is not sufficient to require a group practice of six doctors. These areas will be frequently remote from the district general hospital and consequently the general practitioner may have to undertake some work that would in urban areas be done in the hospital. We believe that the benefits of group practice can be brought to these areas by having a central group practice centre appropriately sited for the best communications. This main centre would contain all the more sophisticated facilities and the ancillary staff. Strategically sited in the surrounding areas would be satellite units which would be visited by doctors and other staff at suitable times. The comparatively modest requirements of such a satellite unit would include a waiting area, a consulting room with examination couch, treatment room and a small office. We have seen admirable examples of this type of centre in the West Riding of Yorkshire and have been told of similar ones in Cumberland.

111. A major problem in the National Health Service is how to persuade doctors to practise in some of the less attractive areas. This is particularly difficult in some of the industrial and mining areas. It was suggested to us that the major factor is not that the doctor would not practise in the area, but that his family did not wish to live there. In nearly all these areas housing suited to the doctor's family can be found within 5 or 10 miles. It was therefore suggested to us that a small bedroom should be provided in a health centre for the doctor on call so that he might then live further away. This suggestion is worthy of further consideration.

112. There will be places where it might be appropriate to build a centre in the grounds of a district general hospital. In these circumstances it might be easy for the functions of a health centre as a primary and continuing care unit to become confused with that of the hospital to the detriment of the services provided for the community. It would be necessary to make a well-defined distinction between the health centre and the hospital by having the former in a separate building. This need not mean that the practitioners should not have full access to all the hospital facilities, including the library and staff common room, etc. The siting of a health centre in the grounds of a district general hospital or a teaching hospital, should provide the opportunity for introducing the undergraduate and postgraduate doctor to the problems of medicine in the community, and these centres would be ideally suited as the base of some university departments of general practice.

The Need for an Immediate Building Programme

113. The need to increase the present building programme is urgent. Although the number of health centres being built, or in the planning stage, is impressive we have pointed out (paragraph 102) that if this pattern is continued only 12.5 percent of doctors will be practising from health centres by 1975. In addition it seems possible that some local authorities may be deterred from providing health centres pending the reorganisation of the health services. Many who gave evidence stressed the importance of accelerating the health centre building programme so that a high quality community health service would be established by the time the district general and "Best Buy" hospitals become operative. We agree with this because we believe that without such a building programme the problems of associating community and hospital care will be much more difficult to solve.

114. The increase in the number of health centres that have recently been built, or are at various stages of planning reflects the desire on the part of general practitioners for the facilities which these centres have to offer. This demand must be satisfied if the momentum and favourable climate of opinion is not to be lost. If centres are not provided quickly enough the enthusiasm for them shown by many general practitioners will wane and frustration will lead some doctors to make other arrangements, not to the long term benefit of the health services.

115. Many witnesses impressed upon us the difficulties, frustrations and delays which often take place before a health centre is built. Many of these problems should be resolved in a unified health service and with area planning, but in the interim period before this becomes a reality it will be necessary to withstand any reluctance on the part of local authorities to build health centres which at a later date will not be their responsibility.

116. Although individual authorities are learning from their own experience there is at the moment no programme that will ensure continuity of experience. There is no programme for collecting evaluating and distributing information about existing health centres and their impact on the quality of community care. In our opinion action to remedy this is urgently required and should be put into effect as soon as possible. We consider this further in Chapter XIII.

117. Whilst questions of financial priority are not within our remit, nevertheless it must be recognised that these decisions have a direct bearing upon the quality of medical care. There is no doubt that in terms of value for money spent the capital invested in the community health services will produce a greater return from which more people will benefit than a similar amount of money devoted to the hospital services. The general medical services in particular have, until recently, received most of their capital investment from the doctor's own gross income.

CHAPTER VII

EQUIPMENT, SERVICES AND ORGANISATION IN GROUP PRACTICE

Diagnostic Services in Group Practice Centres

118. Again we emphasise the general practitioners' needs for open access to diagnostic facilities provided in hospitals. The position with regard to pathology facilities is reasonably satisfactory. Despite repeated ministerial approval of the policy, the provision of radiological facilities has only slowly been implemented and there are still a number of general practitioners with only limited access (30, 31). This is especially so in the large conurbations and in the vicinity of teaching hospitals. It has been argued that the requests of general practitioners for radiology must be vetted by a consultant to avoid unnecessary use of equipment and staff, both of which are scarce. We known of no evidence that general practitioners abuse these facilities. In fact various studies have shown that general practitioners use them with great selectivity. As we have implied in Chapter I (paragraph 14), we regard the practice of using consultants to supervise the work of general practitioners as a wasteful and time-consuming duplication of effort.

119. It was suggested to us that one of the benefits of large health centres would be that they could include radiological and pathology services. This argument was made in particular by those who advocated the concept of the Community Care Unit serving a population of at least 50,000 persons. Whilst we were initially attracted by the idea of providing both pathological and radiological facilities in large health centres, particularly in view of the development of auto-analytical techniques, we were convinced that the duplication of these services would be uneconomic both in terms of the highly expensive equipment and the skilled professional staff which are required to serve and maintain them. Moreover, we were told that the technical staff who would be needed do not, as a rule, like to work in isolation. We therefore recommend that these services should be provided centrally from the district general hospital, and that general practitioners should have direct and full access to them.

120. If the service provided to general practitioners is to be efficient, then there must be adequate arrangements for the transport of specimens, and in some cases patients, and also a quick reporting service. We were told of a system of collection of pathology specimens organised by the local health authority in Bristol. We think that similar arrangements should be introduced in other parts of the country.

121. The use of both pathology and radiology facilities by general practitioners will increase in the future, particularly as younger doctors, with adequate vocational training, enter general practice. One study (32) suggested that the overall use of the pathology services would increase fourfold in 10 years, and another (30) that a similar increase in the use of radiology services by general practitioners might be expected. It is, therefore, very important that this should be borne in mind by those responsible for planning these parts of the health services. At the same time we think that the practicability of developing apparatus suitable for

use in general practice needs further examination both by the general practitioners who will use it and by the technical groups who might devise it.

122. Some simple items of diagnostic equipment are possessed by most doctors but those which are not should be provided in all group practice centres to the extent which will permit suitable diagnostic work to be carried out. It has been suggested that, for example, electrocardiographs, spirometers and audiometers, could more economically be provided in diagnostic centres and used by general practitioners in an area. The experience gained in places where centres of this sort have been established suggests that they are only used regularly by those doctors in close proximity to the centre. These items of equipment should be available in health centres and, with adequate training, general practitioners will make efficient use of them.

Supplies for Group Practice Centres

123. The present position is marked by the variety of sources from which supplies are drawn. For instance, the local health authority is responsible for providing home nurses' equipment—an increasing proportion of which is disposable —while the practitioner draws his supplies of disposable syringes and needles from his Executive Council. Specimen containers, however, are obtained from the hospital laboratory and from the Public Health Laboratory Service. The practitioner's stock of drugs and dressings have to be purchased by him and cannot, as in Scotland, be prescribed on Form EC10A. Material for use in health education, such as literature, displays and films, are obtained through the local authority health education officer. There is much to be said for the central provision of all supplies for all parts of the service, including such things as sterile dressings and laundry services. The supply service should cover the following items:

Syringes and needles.
Sterile dressing packs.
Instruments—including:

(i) Full obstetric packs and sets of obstetric instruments.
(ii) Instruments for minor surgery and casualty work.
(iii) Sterile disposable instruments—catheters, speculae, proctoscopes, etc.
(iv) Laboratory equipment including culture media, swabs, slides, solutions, etc.
(v) Vaccines and prophylaxis materials.
(vi) Anaesthetic and resuscitation equipment, where necessary.

There should be a central laundry service and provision for supply of paper towels or roller towels, examination couch covers, paper over-covers, covering sheets, cubicle curtains, etc. One of the fruits of a unified health service administration might be the rationalisation of supplies.

Transport Facilities for Patients

124. We were told of experiments in the use of mini-buses as a supplement to public transport for bringing patients to group practice centres, thus saving the necessity for some home visits and making it possible for the doctor or nurse

to do more for a particular patient. In one of these studies (34) a doctor's arc was used to bring patients to the surgery. Approximately 25 per cent of the patients requiring a new visit were prepared to come to the surgery by car. There was little abuse of this service which was welcomed by most patients. The cost was little more than £1 per hour but this was saved in the doctor's travelling time. We welcome these studies which should be extended because we believe that they may well provide the solution to some of the difficulties in sparsely populated areas, or in situations where there is extended linear development, as in the Welsh mining valleys. We also think that this facility will need to be provided in urban areas for large multiple-group practice centres. This service should be distinct from the ambulance service and be controlled from the centre for which it is working. Nevertheless, it might provide some much needed relief for the ambulance service and could possibly be co-ordinated with transport facilities to central laboratories (paragraph 120). The facilities provided by public transport should be taken into account at the time of the overall planning of group practice centres, the co-operation of the transport authorities should be sought and the use of buses modified to take easily such things as push chairs.

The Management and Organisation within Group Practices and Health Centres

125. The organisation of a group practice should be the concern of all those working within the practice. It is important that there are clear lines of communication and good relationships between all those working within the group practice. The fields of the various professions should be clearly defined. Each should understand the other and respect the other's capacities and potentialities. Joint planning should take place and members of the group should decide together which is the most suitable service in a given situation. The aims of meetings within the group practice should include:

(i) Providing an opportunity for consultation and collaboration.
(ii) The collection and dissemination of information to all members of the group.
(iii) Settlement of policy affecting the care of patients.
(iv) Ensuring that there is adequate liaison with the hospital and social services.

126. Within a group practice or a health centre the principles of meetings should remain the same. In a multiple group practice or a large health centre there will also be a need for a centre committee on which all staff are represented.

127. The question of leadership within a group was raised by a number of those who gave evidence to us. For obvious medico-legal reasons the doctor must be responsible in all clinical matters. Responsibility cannot be shared by a group. It must be placed squarely on the shoulders of the doctor who will remain, in the truest sense, the clinical leader of the team. It was apparent from the evidence that, apart from the clinical aspect, there would be no support for the concept of a leader who was imposed. The majority were of the opinion that a leader would emerge from the management committee structure which we have suggested. Some advocated that there should be a rotating chairmanship of the committee. The view was frequently expressed that there is a need for some sort of hierarchical structure if group practice is to be stable. We believe that this makes good sense,

but that in each group there must be an insistence upon participation in management and upon defined roles for all members of the health team.

128. Throughout our report we have stressed the need for teamwork. Personalities are therefore bound to be important. For these reasons it is vital that members of a group practice are consulted about the selection of any new staff with whom they will have to work. This ideal may not always be practical during the interim period when health visitors, nurses and social workers are being attached to practices. Nevertheless, even at this stage there is a need for careful preparation before attachment takes place so that the development of good working relationships is not impeded by one team member's ignorance of another's role.

129. In some centres the complexity of the day-to-day non-medical organisation will necessitate the appointment of an office manager who may or may not have a medical or nursing background. Apart from the duties which we have suggested for such a person in Chapter V (paragraph 87(v)) he or she would have an important role in co-ordinating and integrating the work of the centre with that of the department of the community physician.

Appointment Systems

130. A number of surveys have shown that an increasing number of practitioners are now using appointment systems of one kind or another. An appointment system is an indispensable feature of group practice and, properly run, ensures that the best use is made of the time of doctors, nurses and patients. It preserves the traditional doctor/patient relationship by permitting the proper amount of time for consultation and by enabling the patient to see the same doctor.

131. In Chapter V we have considered the role of the receptionist in organising an efficient appointment system. We were told of examples where, when an appointment system was operating, a receptionist appeared to act as a barrier between the patient and the doctor, to the detriment of the doctor/patient relationship and thus the quality of care. We think that an appointment system which does have this effect is not being conducted properly. Every patient should have access to his own general practitioner on request and if a particular doctor is not available he should be given the opportunity either to see a partner or to have a suitable later appointment. Provision should be made in every appointment system to cater for casual or unpremeditated consultation. Patients seen in an emergency by another doctor should, whenever possible, be referred back to the doctor who was originally consulted. Each doctor should work at his own speed without being unduly conscious of appointment timing. Similarly, other members of the health team will often find it satisfactory to make appointments to see patients.

CHAPTER VIII

RECORDS FOR GROUP PRACTICE

132. We have received evidence from many quarters calling for an improvement in general practice records and looking forward to the benefits that it is anticipated might come from the use of computers. Very little detailed evidence was offered, and it may be appropriate, therefore, to review some of the main features of records systems in general practice, to see how far they are adequate for present purposes and how they would need to be modified to serve the full potential of group practice and health centres.

133. The medical record cards (EC 5, 6, 7 and 8), used by general practitioners in the National Health Service, have existed in an almost unchanged form ever since the introduction of the National Health Insurance system in 1912. The peculiar lay-out of this record in an envelope which does not conform to international paper sizes, does not lend itself for use as a records system although it is easy to carry around. The Records and Statistics Unit of the Royal College of General Practitioners, and many doctors, have devised ways and means of improving the capability of this record, but as Kuenssberg (35) has emphasised, any records system can be made to work by the individual doctor but it stands or falls as a national system on whether or not it induces the generality of doctors to keep adequate clinical records. This the present forms EC 5, 6, 7 and 8 do not do. It is difficult to envisage a satisfactory format for a record which is confined to the size of the present National Health Service Record.

134. For many practitioners working with a fairly stable list of patients, particularly for those who are single-handed, there may seem little purpose in keeping detailed records. The doctor will be familiar with much of the clinical and social history of his patient, and will need only a short note to remind him of new episodes or progress in established conditions. The records which, combined with his memory, provide for him a sufficient account would, however, be quite insufficient as a guide to any other doctor looking after the patient. In any event, abbreviated notes can be unsatisfactory to the practitioner who made them because memory is fallible and events in the past may be forgotten and recalled incorrectly if they are not documented at the time they occur. The quality of medical care even in the case of a single-handed general practitioner is to some extent dependent upon the manner in which he keeps his records.

135. In a group practice, even though the principals usually look after their own patients, there will be more occasions on which a doctor has to see a patient with whom he is not familiar. It becomes all the more important that the record is complete in all essentials. Some agreement in format and content of the record clearly makes it easier for different doctors to obtain the information they want from it. As the group practice team grows there will be an increasing number of allied professional workers who will be documenting their activities, and the doctor will want to make use of the information they have obtained. Equally,

these other members of the team will need to have information from the doctor. At the present time there are in existence a number of local health authority records (the birth record, the 0–5 record, the school medical record and the home nurse's record) which are all related to an individual and which often contain duplicate information. More important, however, the information in any one of these records is not readily available to other members of the team. The group practice with attached local authority staff—health visitors, home nurses, midwives, social workers, etc.—becomes increasingly involved in preventive work and this trend will be fostered by the changes proposed in the Green Papers 1970. The practice records will, therefore, contain items concerning immunisation, ante-natal examination, child development, results of screening tests, etc., which require orderly and accurate documentation. The pressure for uniformity within a group and between groups becomes more intense. A complication in this system which, for one doctor, could be simple, is that the relevant detail for any one patient may be scattered among records kept by different people, and yet to manage the patient efficiently a member of the team may need access to any or all of these different records.

136. We agree with those who gave evidence that the many separate medical records in the community should be integrated. The present time is particularly opportune to undertake this task because of the development of the group practice team in which all the staff concerned with an individual patient will be concentrated under one roof, and therefore have potential access to one record. This eliminates the need for multiple records for clinical purposes, except for communications about patients to others in the hospital service, special medical care departments or social services departments. Furthermore, it makes it possible to capitalise upon the unique epidemiological and clinical potential of the general practitioner's record which can chronologically cover the medical history of an individual from birth to death and which is transmitted with the person wherever he or she moves.

137. The prime objects of any medical record are to serve the needs of the immediate and any future clinical problems. The medical and associated records kept in a practice help the team to provide good medical care, but they also provide, as should any medical record, the basis for research. They can have an important function as sources of data about the population. They can be used to describe morbidity in the group, and how it affects the various sections of the community. They can provide a measure of work-load and how it is distributed, and the demand made by the practice on hospitals, local authority services and other agencies. They can indicate changes in the pattern produced by outside influences and the degree to which alterations in the organisation and conduct, not only of general practice but also of the whole health service, have affected the population that is served.

138. If these objectives are to be realised the records system has to be designed purposefully so that statistical data can be extracted easily. There is, however, a conflict between the data which needs to be recorded for purposes of day-to-day clinical care, for use in future episodes of illness, and for research. Much of the information recorded for day-to-day clinical purposes has little relevance in future episodes of illness. The single most important item, the diagnosis, needs to be abstracted from the routine record. The data which may be required for research purposes is infinite, but a record that will make it possible to record

certain basic characteristics about a patient, such as age, sex, occupation, blood group, drug sensitivity and family medical history, will, together with a record of morbidity, provide the basis for a great deal of research. A clear cut distinction between the data recorded for each of these reasons must be made if the record is to be so designed as to encourage doctors and other workers to use it efficiently.

139. One of the major problems of a medical record which serves the needs of both a number of doctors and a variety of other staff is that it becomes increasingly difficult to maintain confidentiality in any part of the records system. The danger of losing confidentiality can be minimised if the record is only available to the members of the group practice team and their staff. All these persons should be made aware of the need for maintaining confidentiality. At the same time the individual patient must be educated to understand that modern medical care can only be achieved, in many instances, by a team approach, and that consequently it is necessary for doctors and nurses to have access to the same record. The use of computers in medical records need not result in any loss of confidentiality because computers can be programmed in such a way as to restrict access to a limited number of individuals, and only selected data need be stored in computer files.

140. For the reasons outlined in the preceding paragraphs we recommend that the records system currently in use in the general medical services of the National Health Service should be re-designed and that, at the same time, some of the records at present in use in the local health authority should be integrated with those of the doctor to make a record which can be used by all members of the group practice team.

141. An ideal records system for group practice would:

(i) Provide all the information, from whatever source, which might be valuable in caring for the patient.
(ii) Maintain the confidentiality of information given by the patient to the individual members of the team.
(iii) Operate as a source of morbidity and other data on the population served by the practice and, in this, be compatible with data from other sources in the area.
(iv) Be so designed that it is possible to link the general practice records of a patient with medical records from other sources such as hospitals, vital registrations, etc.
(v) Serve as a source for studies of the operation of the service, demands made on it, how these are met, and the variations in time and place.
(vi) Enable assessments to be made of the effectiveness of the medical service.
(vii) Be so designed as to encourage the majority of doctors and other staff to maintain it in a proper manner.

142. The aims outlined in paragraph 141 will not easily be met in one system, but data processing machinery will go a long way to make this possible. Computers facilitate the storage of data which can be retrieved readily and hence they could satisfy the needs of patient management. They can be programmed to produce statistical data as a by-product for this purpose. They can perform easily and more accurately than traditional methods the tedious steps involved in successful record linkage. They can be programmed to assist in the practice routine, for

example, in the recall of patients or in the organisation of screening procedures. The advantages of a computerised system are not easily realised, however. It has been indicated that, as the system grows more complex, standardisation of terminology and procedure becomes more essential. A computerised system would leave virtually no freedom for separate practices to choose how they kept their records because, to function economically, it would have to cover a large population. The labour and cost of data preparation would be another significant factor and a choice would be required between data which would be handled by the computer and data of less permanent significance which would be kept by traditional methods and possibly destroyed after a short interval. It is possible that eventually all information might be entered into the computer direct without a written record as an intermediate step, in which case the computer could be programmed to select what was to be retained. Such a fully automated system is not yet feasible. For the present, the decision on how far computerisation can help general practice records systems can be made only after the objects of the exercise have been clearly defined and costed, and the specification tested in pilot projects. It should be possible to design a new records system that could be equally capable of use either with a computerised or a manual system. Indeed, it is essential that any new records system must, in the immediate future, be adaptable to a variety of local situations.

143. We are aware that experiments into the design of medical records are going on in a number of places. The composition of this Committee is such that we cannot make detailed recommendations as to the format of a new record for general practice. We therefore recommend that a committee should be set up as soon as possible to consider not only the detailed design of a record for the group practice team, but also the whole question of medical records in the community and record linkage with the hospital services. An essential prerequisite to the introduction of computerised medical records will be a national agreement upon a form of patient identification.

144. When a new record is designed, we do not think it would be possible to retain the size of the present general medical services record folder. The logical change to a standard-sized folder would, we realise, be costly but we are convinced that the expense is necessary if full value is to be obtained from the record system.

145. We were particularly asked, as a Committee, to comment on the need for, and the value of, a personal medical record which could be carried by individuals and which would contain selected details about a person's medical history which might be of importance. Quite apart from the difficulty of deciding what to record on such a card, we doubt whether the people in this country would, in fact, carry such a record with them unless they are members of a specially motivated group such as diabetics or patients receiving steroid or anticoagulant therapy. These patients and possibly similar groups, should continue to be supplied with special cards which they should carry on their person. There should be a common design for these cards and in Appendix E we suggest a possible form for such a card.

CHAPTER IX

GROUP PRACTICE AND THE COMMUNITY PHYSICIAN

146. We have made a number of references in our report to the community physician and the role of his department in relation to the work of group practice. As yet the community physician does not exist, and indeed he cannot exist until a unified health service is established. The term "community physician" has, however, been used in the Green Papers (2) which contain a very broad idea of the role of such a person. Group practice will be directly affected by a person with this sort of co-ordinating function in the health service. We are aware that a Working Party has been set up to review the functions of medical administrators in the health services and to make recommendations regarding the provision required for their training. Whereas we do not feel that, at the time of publication of this report, this Committee is in a position to define all the functions of the future community physician, we are unanimous in believing this role to be of the highest importance in the future development and integration of the Service, not only in the community but equally in hospital.

147. We see the role of the community physician and his department as including much of the work of the Medical Officer of Health and his department, and we see great potential benefit in enlarging this role to obtain an overall view of the total health services and the total health needs of an area. We think that such a service should have the machinery for continuous monitoring of disease, with the objective, amongst others, of identifying needs that are not being met and of maintaining a balance between the various branches of the health service in terms of need, available finance and professional manpower. This will necessitate the development of epidemiological and work studies both in group practice and hospital along with medical audits as a continuing process. The stream of knowledge gained from such monitoring services should be of direct assistance to clinicians and administrators in all branches of the health service in appreciating needs and evaluating their own contribution.

148. There are certain other services which can only be promoted effectively by a medical department which has a responsibility for an area as a whole, and group practice will be affected by the efficiency with which these services are administered. Included in this category are: formal health education, immunisation, the school health service, and the organisation of the personal health care for special groups within the community such as the chronic sick, the mentally and physically handicapped. All these services will have to be closely integrated from the clinical side with the appropriate hospital department and the group practices within an area or district, and also with the social services department of the local authority with which the community physician will need to maintain a close liaison. This would be particularly important in securing appropriate long term secondments of social workers to group practices, as suggested in the Seebohm Report (14). The development of an integrated medical and social casework service within group practice will depend on such secondment.

149. There are administrative functions which can also only be rationally undertaken for an area as a whole and which will fall within the field of work of the community physician. These would include participation in the planning of the health services for an area, especially the siting of hospitals and group practice centres; the development of lines of communication; record linkage; and the use of computers.

150. Community physicians must be deployed at all levels of the National Health Service. At higher levels we foresee that they may need to specialise. At district level they should be in as much personal contact with clinicians, both in group practice and in hospital, as is possible. To this end we should like to see a community physician personally associated with each group practice so that general practitioners could have direct access to him and his colleagues. In speaking of a generalist community physician at district level, we are assuming the presence of specialists in particular fields of community medicine at higher levels, to whom reference might be made at any time.

151. In the past, some duplication of work between the local health authority and general practitioners has inevitably developed as the latter have become more and more involved in preventive medicine and because they have, in recent years, been able to consider not only individual patients who consult them, but, by virtue of having definable lists of patients, the whole population of the practice. The overlapping and lack of integration of some services, which have been evident during the past half century and have been wastefully perpetuated by the tripartite system in the National Health Service, must be carefully avoided in the future. Care must be taken to see that, through custom, the existing local authority health departments are not simply transposed to any new area health authority, and existing divisions of the health service perpetuated. A satisfactory conclusion could be achieved by the very close integration of the general practitioner and community physician services, as suggested in paragraph 149, whilst clinical, epidemiological, and preventive work would also be better effected by day-to-day contact between colleagues serving a common patient population.

152. We recognise that it may be found desirable for some community physicians to specialise in certain fields of work, examples of which are given in previous paragraphs, and for them to be involved in certain areas of clinical work although not in total patient care. We expect that these activities will develop as an integral part of group practice and that such clinical work as is undertaken by them would take place within the health centre or group practice or, where appropriate, within the district hospital, in order to maintain the closest touch with the clinicians normally caring for other aspects of the patients' health.

153. It is as important to reduce to the minimum the number of persons simultaneously giving clinical care to each patient as it is to avoid duplication of services. For instance, clinical maternity work should be carried out within an integrated hospital and general practitioner maternity service. Similarly, new areas of clinical work, such as developmental screening in paediatrics, family planning or a drug addiction service, would best be planned as integral parts of the paediatric and psychiatric services, or within the general practitioner service, whichever is appropriate. Changing needs will, in future, cause changes in the areas of skill required in every discipline, and possibly changes in the size of their departments. There should be sufficient flexibility in every discipline to meet this

prospect and to absorb new areas of clinical work in a planned way. We see the role of the community physician mainly in identifying such new needs and, with his specialist staff, developing and integrating such new services.

154. In paragraph 23 we refer to the possibility of general practitioners developing special fields of interest. In these areas community physicians may have an important role not only in ensuring that no group of patients is forgotten in the overall service, but also in contributing special knowledge and skills. This role will be of particular importance in the period before general practitioners have had time to acquire the extra skills and develop the organisation required.

155. It is of great importance that the community physician should take part in teaching at all levels: medical undergraduate, postgraduate and continuing education, and in the nursing and social services training schemes, so that all disciplines develop an awareness of the health service as a whole and of its composite parts, and a wider appreciation of the common aim.

156. It would be a great advantage for the community physician to have a significant experience of general practice during his own postgraduate training, in addition to his time in hospital appointments, so that he has first-hand knowledge of the working and problems of both. Recruitment to this field of work would naturally come from the departmental medical officers of the local health authority and we are aware that experiments in the re-training of these officers are already taking place in some parts of the country. We also agree with the suggestion in paragraph 144 of the Gillie Report (6) that it should be possible for general practitioners and, perhaps, others to enter the community physician service at any stage in their career, on acquisition of the appropriate qualifications. Such interchange would contribute to the integration of the work of general practitioners and community physicians.

157. We recognise other functions of the community physician not immediately relevant to this report, among which would be his role as adviser to the local authority environmental health services, adviser to the local authority social services department, and adviser to any new area health authority.

158. An important function of the community physician would be to integrate the work of the hospital and community services. It will therefore be essential for him to be as closely associated with the former as with the latter.

CHAPTER X

THE RELATIONSHIP OF GROUP PRACTICE WITH OTHER DISCIPLINES AND PROFESSIONS

Part 1: Rehabilitation

159. "In Britain the expression 'rehabilitation of the sick and injured' is used to define a continuous indivisible process which, starting from the onset of sickness and injury, comprises all the measures used to prevent undue loss of physical and mental function during illness, to assist convalescent patients to recover full function and to resume their normal way of life without undue delay and to help those for whom disability is permanent to adapt to their residual disability and to live and work in the conditions best suited to their capacity" (36).

160. To some extent such measures form a part of the management of any illness but they need special emphasis when illness or disability is severe or prolonged, or when complete recovery is unlikely or uncertain. In such conditions the hospital service is likely to play a leading part, particularly in the physical medicine and the geriatric departments. There are also specialised rehabilitation centres serving large areas. The Department of Employment can make an important contribution through its Industrial Rehabilitation Units, Government Training Centres and Disablement Resettlement Officers. We do not need to enlarge on these services here, as another Sub-Committee of the Standing Medical Advisory Committee is at present giving detailed consideration to rehabilitation in the National Health Service (37), but we would stress that the general practitioner is primarily responsible for the medical care of the disabled population living in the community and the experience and advice of the staff of the group practice may be vital to the correct management of the patient's problems. As long ago as 1956 the Piercy Committee (38) said: "in this field the general practitioner may enjoy advantages denied to hospital medical staff. Longstanding personal knowledge of the patient may enable him not merely to diagnose and treat effectively but to assess the patient's personality and capabilities very readily and to advise confidently on the future course of action. Local knowledge of industry and personal contacts with employers may enable him to give great help in advising on placing in employment and resettlement. But to serve the patient's interests most effectively, the general practitioner must be able to call on, and be ready to use, the services of the other members of the local team who can help him—the health visitor, the [social services] officer, the disablement resettlement officer, and so on." This is no less true today, and provides a further reason for the incorporation of the health visitor and social worker in the group practice team, and for this team to establish good lines of communication with the disablement resettlement officer of the Department of Employment and the regional medical officer of the Health Departments, on the one hand, and the hospital departments concerned on the other.

161. Physiotherapy, including remedial exercises and instruction in daily living, can play an important part in rehabilitation, and will be considered in the next section of this chapter.

Part 2: Physiotherapy

162. A widespread desire for physiotherapy either in the home or close to the homes of the elderly and disabled was expressed by many of those who gave evidence to us. The hospital services have refused to meet this demand on the grounds that resources of staff are scanty, and have supported this refusal by drawing a distinction between open access to diagnostic services, such as radiology and pathology on the one hand, and therapeutic services, such as physiotherapy, on the other.

163. Many witnesses have given us evidence that help from professions ancillary to medicine may be given to group practice without prejudicing the recruiting possibilities of the local district hospital. Married women physiotherapists might willingly undertake part-time work in group practice, but many would not return to full-time or even part-time work in a hospital department. There may thus be a considerable untapped source of physiotherapeutic skill which, with some suitable retraining, might be of direct benefit to patients near their own homes. The district general hospitals of the future, if developed along the lines suggested by the Bonham-Carter Committee (39), will be larger and fewer and therefore further from the homes of the hospital workers who have left hospital to get married, and also further from the homes of most patients. It has been reported to us that although most hospital physiotherapy departments have staffing difficulties there are at present at least 6,000 trained physiotherapists who are not practising their profession.

164. It was suggested to us that the shortage of physiotherapists would be less serious if all those available were employed to the best advantage, but this is not being done in all hospitals because many doctors lack sufficient knowledge of the present-day role of the physiotherapist. This role is changing from the former concept of a therapist, who applied specific treatment such as massage or electrotherapy to a passive patient, to the modern therapist whose predominant role is to train patients to help themselves to regain function through remedial exercises, and to overcome disability, if any, by means of aids and appliances. Moreover, witnesses have impressed upon us that recent experience suggests that short intensive treatment sessions, daily or twice daily, are more effective in producing results and are more economical in use of staff than treatments given at longer intervals. To some extent the desire for domiciliary and/or group practice physiotherapy may be based upon outmoded concepts of what physiotherapy has to offer.

165. Whilst we accept these arguments, nevertheless we believe there is a need for some physiotherapy services outside the hospital, and that these could probably be best provided in association with the group practice team, with well-established links with the hospital department of physical medicine.

166. Some of the conditions which particularly lend themselves to this type of treatment are:

(i) The prevention of disabilities and the prevention of the progression of disabilities. This will become more and more important as the numbers of persons with chronic degenerative disease increases.

(ii) Hemiplegics—these patients often go home to unsuitable conditions out of reach of the day hospital. Maintenance of function and adaptation to daily living is an important task if the results of intensive hospital treatment are not to be lost.

(iii) Stress incontinence—the prevention and treatment of stress incontinence by re-education of pelvic floor muscles.
(iv) Chest conditions—the supervision and training of patients in breathing exercises or postural drainage.
(v) Orthopaedic conditions—the supervision of active exercises in a variety of orthopaedic conditions and the application of simple traction apparatus in intervertebral disc lesions.

167. It must be recognised that it is not only those patients who have been in hospital who require physiotherapy and rehabilitation. The assessment of every individual case by a consultant in physical medicine, besides being unnecessary if general practitioners are adequately trained, will result in a demand on the consultant services which cannot be met.

168. A physiotherapist, working with a group practice team, could achieve a great deal in partnership with the home nurse so that those in constant attendance on the patient can be taught the necessary procedures. In this way, and by instructing the relatives, rehabilitation can become a continuing process.

169. We received little evidence of a practical nature that can serve as a guide to the possible shape for physiotherapy in group practice premises. The experience of deploying a hospital-based team into appropriately large health centres has led to the conclusion that there is a gain in convenience and a saving of travelling time for patients, at a cost of extravagant use of trained staff. It was suggested to us that the essential accommodation and equipment required by a physiotherapist at a group practice centre might be:

(i) Two treatment cubicles, about 8 ft × 8 ft, with overhead mesh for supporting limbs; and slings and bars, adjustable in height at one end for lumbar and cervical tractions, and with provision at both sides for the attachment of weights and pulleys to provide graduated resistance exercises.
(ii) A model bed-sitting room and lavatory for training the disabled.
(iii) An exercise area, for individual and group remedial exercises, with wall bars and parallel bars.

170. After careful consideration of the whole problem, we conclude that:

(i) Too little is known for us to make any firm recommendations as to the exact way in which the physiotherapy services might be provided in group practice.
(ii) Nevertheless, the attractions and advantages of providing such a service close to the patient's home seem obvious.
(iii) There is a very real need to provide training for general practitioners and, for that matter, hospital doctors as well, in the modern concepts and uses of the physiotherapy services.
(iv) There is a place for grant-aided research into the development of physiotherapy in group practice under stringent cost benefit control. Circumstances favourable to this would seem to be the presence in the practice of a general practitioner having some experience of physical medicine, availability of part-time physiotherapists in the neighbourhood and the existence of premises suitable or easily adapted for the work. We understand that a project of this nature has already been planned.

(v) There is an obvious need for the closest integration of physiotherapeutic services in hospital and in the community. Probably the district general hospital department of physical medicine will undertake the major task of building up a momentum of re-education in training patients to help themselves. In group practice premises this momentum might be maintained by part-time physiotherapists, themselves in contact with their hospital colleagues and familiar with the hospital's methods and objectives. The nurses of the group practice, in contact with the group practice physiotherapist and familiar with the home surroundings of particular patients, might bring to light peculiar difficulties in the patient's home and ensure that neither apathy nor increasing infirmity allow progress to be halted or ground gained to be lost.

(vi) To build up and maintain such integration, close consultative relationships must be built up between family doctors and their hospital colleagues specialising in physical and geriatric medicine. The part-time physiotherapists working in group practices should establish personal contact with their hospital colleagues. The nurses of the group practice should look to group practice physiotherapists for instruction and advice on those simple measures that can do so much to alleviate the lot of the disabled and infirm in their own homes.

Part 3: Pharmacy

171. The role of the pharmacist has been radically affected by recent advances in therapeutics. He now seldom prepares and compounds medicines extemporaneously, but dispenses tablets and preparations which are often prepared by specialist manufacturers. The dispensing of pharmaceutical products is also, in many pharmacies, accompanied by the sale of a wide variety of other goods. Indeed the economic viability of the pharmacy often depends upon this latter activity.

172. The future role of the pharmacist lies, we believe, in the following fields:

(i) In giving advice to doctors regarding the composition and pharmacological action of a wide variety of different drugs and preparations of drugs. This function seems likely to become more and more important as the number of new preparations produced by the pharmaceutical industry increases.

(ii) In checking the prescriptions of doctors, in order to avoid errors of dosage and the danger of incompatibility of drugs, etc.

(iii) In giving appropriate advice to patients to whom drugs are prescribed or drugs which a person may request. This may be in relation to the correct administration of the preparation or, as in the case of monoamine oxidase inhibitors, the warning to avoid certain foods. This does not absolve the prescribing doctor from being primarily responsible for giving similar advice.

(iv) In participating, as members of the health team, in campaigns designed to educate the public about health promotion and prevention of ill-health.

173. For the reasons outlined above we believe that there are obvious advantages if the pharmacist could work in the same premises or in close proximity to the doctor so that communication between them became easier, and so that the

patient could have his prescription dispensed at the same time as he visited the doctor.

174. The Pharmaceutical Society, in their evidence to us, stressed the great importance that they place upon the role of the pharmacist in the giving of advice on medicines to those members of the public who ask for it. They were concerned that the disappearance of the local pharmacy, which might follow if the service for an area were concentrated in relation to group practice, would deprive the public of this particular role of the pharmacist. We know that many people who feel ill do consult their local pharmacist a long time before they consult a doctor, and this has been shown by a survey in London by Butterfield (40).

175. The Pharmaceutical Society pointed out that careful consideration should be given to the effects on the provision of the pharmaceutical services of the establishment of group medical practices, either in health centres or in group practice premises. Prior to the establishment of group practice centres it would be normal, in an area, to have a number of surgeries conducted by individual general practitioners. It would also be usual to find one or more pharmacies relatively close to each of the surgeries. The concentration of medical practitioners in group premises will have the effect of localising the points at which the great majority of prescriptions in an area are issued, with the result that the economic viability of some pharmacies might be jeopardised since they no longer receive the necessary high proportion of prescriptions. This is an inevitable concomitant of the development of group practice and we therefore recommend that, at the earliest possible stage in the planning of health centre or group practice premises, consultation should take place with representatives of the pharmaceutical profession in the area on the necessary provision of the pharmaceutical services. The Executive Council should be responsible for arranging consultations with representatives of the Local Medical Committee and of the Local Pharmaceutical Committee. The Local Pharmaceutical Committee, presented with all the facts, could then consult with the pharmacists who will be affected by the establishment of new premises, with a view to deciding upon the optimum distribution of pharmacies in the area. The location of pharmacies should, as far as is reasonably practical, meet the needs of the public for the dispensing of prescriptions likely to be issued elsewhere in the area, and the provision of advice on medicines to residents in the area. In some cases the best arrangement might be the establishment of a pharmacy adjacent to the new premises by a consortium of the proprietors of the pharmacies in the area, plus an agreement to close one or more of the existing pharmacies, while leaving an adequate number in the correct locations to serve the community. In considering the planning of pharmaceutical services in an area surrounding a group practice centre there is a need to consider controlling the number of National Health Service dispensing Contracts so that the agreed plan could not be disturbed by a new point at which National Health Service prescriptions could be dispensed. Methods of achieving satisfactory arrangements are a matter for discussion between the Health Departments, the Pharmaceutical Society of Great Britain, and the Central National Health Service (Chemist Contractors) Committee, and the British Medical Association, and may concern the Medicines Commission.

Part 4: Chiropody

176. Chiropody services are provided by most local health authorities and have been incorporated into some health centres, but they have been largely devoted

to the needs of the elderly and treatment has, therefore, necessarily been mainly palliative in nature. The patient's needs for chiropody are similar to those we have discussed in relation to the physiotherapy services. The means are, however, much easier to provide. A visiting chiropodist, given the use of a group practice treatment room with suitable equipment and some clerical help, would, we were told, be able to treat eight patients in a three-hour session.

Part 5: Dentistry

177. During the course of our visits to health centres we were impressed by the fact that dental suites, which are provided in many of these buildings, were rarely being used. We were told that they were used only by dentists employed by the local authority in the treatment of children and expectant and nursing mothers. This seemed to us to be a great waste of expensive equipment and accommodation. We understand that there are often difficulties in arranging that the suites provided for the local authority dental services should also be made available to the general dental services for which Executive Councils are responsible, but we consider that every effort should be made to do so. The need for flexibility in the use of such accommodation should be borne in mind at all stages in the planning, building and use of health centres.

178. We considered the possibility of providing in group practice centres common facilities for the full range of community medical and dental services. At first sight there are some obvious advantages. Both professions place increasing importance upon the preventive aspects of their work and both see a certain value in screening programmes. It is obvious that if groups of doctors and dentists were to work together in the same premises the results of work in this field would be enhanced. Furthermore, consultation between the dentist and the doctor would be facilitated over such problems as dentistry for epileptics, dental anaesthesia for diabetics and the potential hazard of bacterial endocarditis following extraction of teeth in patients with congenital or acquired heart disease. Pathological and radiological examinations might be made easier and economies effected in the common use of nursing, clerical and receptionist staff. If a large centre is relatively cheaper to build, and if a large organisation is less costly to administer, there may be economic advantages in arrangements by which doctors and dentists share the same building.

179. The inclusion of local authority medical and dental services in the same building presents no general problems, so far as we know, and has been quite normal practice for many years in most health centres. The position is rather different for the general medical and general dental services. Both professions have hitherto discouraged the sharing of premises by general medical and general dental practitioners. Among the difficulties are the differences in responsibilities towards patients, differences in remuneration and in the method of recovery of practice expenses between the two professions.

180. We have already suggested (paragraph 177) the desirability in certain circumstances of bringing together the local authority and general dental services. There may well be a case for closer organisational links between these services as well. If the difficulties referred to in paragraph 179 can be overcome, it seems to us that the dental services and the medical services for a community could with advantage be provided to an increasing extent from a common building. We there-

fore welcome the trend, which we understand has developed in the last year or two, towards the inclusion of general dental services in health centres (which have long included local authority medical and dental services and general medical practitioners). We would urge that wherever local and personal factors favour such an experiment, similar grouping might take place in group practice premises. The results of such schemes and those already in operation should be studied by both professions.

CHAPTER XI

THE RELATIONSHIP BETWEEN THE HOSPITAL AND GROUP PRACTICE

181. Although our primary purpose is to examine group practice, this cannot be considered in isolation from the hospital-based services. A co-ordinated pattern of medical care can only be achieved if the inter-dependence of the hospital and community health service is appreciated and the necessary resources are provided and properly distributed. Furthermore, the rational and economic deployment of the health services demands not only a continuing assessment of the total health needs of a particular community, but also a willingness on the part of all concerned to make a critical evaluation of their methods of work and a readiness to depart from tradition.

182. It is fundamental to our theme that each medical service should be provided in the appropriate medical and social context. It is illogical and uneconomic to furnish costly hospital services for those who could be cared for equally well in a community setting. Until recently little recognition has been given to this concept in the planning of new hospitals. Crombie and Cross (1959) (41), estimated that up to 43 per cent of the patients admitted to a large Birmingham hospital did not need the diagnostic and therapeutic services at the level provided there; Forsythe and Logan (1960) (42), in Barrow found similarly for 25 per cent of male and 40 per cent of female subjects; and a recent Departmental study (43) of general hospital in-patients indicated that no more than 2 per cent were receiving intensive care for acute illnesses, a further 70 per cent were having treatment for a diverse range of more or less routine conditions and, of the remaining 28 per cent, it is questionable how many required continuing hospital in-patient care. This indicates that substantial numbers of patients were inappropriately using costly hospital facilities.

183. Some patients, in particular the elderly, are adversely affected by removal to hospital—but the impact of this is reduced if the hospital is near their homes. The situation will inevitably become intensified as the district general hospital becomes bigger and therefore more remote from most people.

184. Despite increasing recognition of the inter-dependence of hospital and community care, relatively little has so far been achieved in integrating these two components of the health service. This is particularly due to the tri-partite administration of the service, the legacy of out-dated hospital buildings and the relatively slow development of general practice. However, some of the responsibility often lies in individual failure to appreciate the contemporary need to provide a co-ordinated pattern of medical care. This unawareness itself has been largely fostered by the compartmentalisation of everyday professional lives. When people are ill the aim should be for them to be cared for at home and in the community unless the specialist services of the hospital are necessary. Achievement of this aim depends on adequate and properly organised community medical, nursing, social and welfare services which are not, at the moment, fully developed

and capable of accepting the load. Lack of these functions has resulted in the present situation where a significant proportion of patients in hospital are there, not because of medical needs, but because of lack of provision for their care at home. The degree to which people can provide for themselves has been affected by full employment and equal pay for men and women and other sociological and demographic conditions. This is an additional argument for the provision of nursing beds.

185. From the foregoing it is apparent that there could be economic and humanitarian advantages, without loss in the quality of care, if, in the future there was a change of emphasis away from the hospital towards care in the community.

Hospital Beds for General Practitioners

186. Small hospitals in the community came into being because small populations needed hospitals and the local general practitioners were the only doctors available to staff them. The Gillie Report 1963, (6), saw general practitioner hospitals falling into three classes:

(i) Cottage hospitals staffed by general practitioners.
(ii) Hospitals staffed mainly by specialists of the S.H.M.O. grade with help from general practitioners.
(iii) Hospitals staffed for day-to-day work by general practitioners with consultants visiting for clinics and both surgical and medical in-patient work.

The report went on to state that the range and standard of work of family doctors is increased when they have hospital beds for their patients who cannot be nursed at home, and recommended that:

(i) Many hospitals, in rural areas, staffed by general practitioners and visiting consultants, should be retained.
(ii) Experiments should be encouraged in the use of surplus general practitioner hospitals as health centres providing preventive, general practitioner and consultant services.
(iii) Experiments should also be made in the use of general practitioner beds at existing acute general hospitals.
(iv) General practitioners must have access to some of their patients admitted to the local hospital and retain continuing responsibility for their care.

187. The Hospital Building Programme of 1966 (44) foreshadowed further experiments in the use of small hospitals, either for patients who no longer require the full facilities of the district general hospital and who could be cared for by their family doctors, or for use as out-patient centres. Cottage hospitals vary much in size, design and usefulness. Their siting owes much to local history. Many still have minor casualty departments, and visiting consultant out-patient sessions are carried out at many others. There is much good evidence that where general practitioners have access to these hospitals, the standards of general practice are high. From the evidence that we received we are convinced that most general practitioners could undertake the care of some patients in hospital, provided that the hospital was easily accessible.

188. The Bonham-Carter Committee, in paragraph 33 of their report (39), stated that they did not think that there is a good case for retaining smaller hospitals in places from which it is easy to reach district general hospitals. They also doubted the necessity for retaining those smaller hospitals which were remotely situated or inaccessible from the district general hospital. They did, however, recommend that many peripheral country towns could sustain a small hospital unit, described as a "Peripheral Hospital Unit", and suggested, in paragraph 34, that the work in such units should be severely limited with regard to its medical scope. In paragraph 37 they advised that the whole unit should be regarded as no more than an out-post of the district general hospital. We question the validity of some of these recommendations and feel that the place of the smaller hospitals should be reconsidered, not necessarily as extensions of the district general hospitals, but as constituting the nucleus of a local nursing unit (see paragraph 192) which could logically have associated with it local group practices or health centres. We feel that if these smaller hospitals were looked at in this light, then many of them would usefully continue to serve the community in a newer, contemporary role.

189. The present lack of contact between the hospital and community services was expressed to us, by many general practitioners, in the form of a desire for hospital beds in which to treat their patients. The same reason has, we believe, led to the recommendation, in a number of reports and publications, that the general practitioner should be involved in hospital work. The opinion was expressed to us that future generations of general practitioners will be anxious to continue to exercise the skills learned in the hospital part of their training and it was argued that one way of doing this will be for them to undertake full responsibility for caring for patients in hospital. A contrary point of view was that to function properly as a specialist in general practice does not allow the time or diversion of effort that caring for patients in hospitals demands. Theoretically this situation should be improved by better organisation of general practice. However, the time saved in this way is likely to be taken up in providing a higher standard of patient care in the community.

190. It appears to us that much of the difficulty in interpreting the evidence which we received is due to the confusion which exists as to what is meant by access to a hospital bed. It seems to us vital to draw distinctions between the purposes for which beds are needed. It is further apparent to us that any assessment of the numerical needs for hospital beds for general practitioners is likely to be very imprecise and dependent upon a number of local factors. Our review of the need for the various types of hospital beds must be taken in this light.

191. Social necessity rather than medical need, accounts for the presence of the majority of those patients who are in hospital but who do not need the facilities of the hospital. Other than nursing care, these patients do not require any greater medical attention that the general practitioner would be able to give by visiting the home, and do not need the facilities which the hospital provides. This unnecessary component of hospital work is even higher if one includes those whom investigation has shown to be less ill than the initial diagnosis suggested but who cannot be discharged or transferred for lack of care elsewhere. These are patients suffering from illnesses that the general practitioner could have managed at home had the domestic facilities been adequate.

The Concept of the Nursing Unit

192. From a consideration of the evidence we conclude that, whilst we agree with the recommendations of the Bonham-Carter Committee that as many as possible of the hospital services should be concentrated at one point, there is also a need for more continuous nursing care in the community than exists at present. The patients for whom this is required are those who, for domestic reasons, cannot be treated at home but who do not need consultant management. They could be cared for in nursing units. These, though similar to the present cottage hospital, would not contain the sophisticated resources appropriate to a district general hospital. Such evidence as we possess suggests that they would be economically justifiable and indeed would represent a considerable asset because they would avoid unnecessary admissions to district general hospitals. They would provide medical and nursing care in quieter and more intimate surroundings and would maintain the link between the patient and the group practice team whom he knows. In this way we believe these units would provide an effective and acceptable service more related to the specific needs of the patient. They would realise the nursing potential in the community without prejudicing recruitment to the hospital and would enlist local goodwill. They would increase the range and quality of work of general practitioners. These factors almost certainly explain some of the public concern that is being expressed at the closure of smaller hospitals.

193. Without doubt, one of the major reasons in favour of the closure of these small hospitals is that they are said to be extravagant to maintain. This may be because there has been a tendency for some of them to produce a service to satisfy general practitioners and patients in a manner unrelated to the requirements of modern medicine in the community concerned. Examples of this are the provision of diagnostic radiology and surgical facilities which are not economically used. We were unable to obtain accurate national figures for direct comparison of the cost of hospital beds with only nursing care, with that of beds where the full range of sophisticated hospital treatment would be available, but we believe that units providing simple nursing care only, must, a priori, be less expensive than beds in a large hospital. Figures we have seen for the Ipswich area demonstrate that the cost of providing a bed with full diagnostic and surgical facilities is nearly double that of one providing only nursing care. A study of the New Zealand hospital statistics (45) would seem to confirm this. There is an imperative need to produce figures for this country.

194. The term cottage hospital has a connotation of simplicity and economy and conveys a feeling of warmth and homeliness. Moreover the cottage hospitals of this country have established an honourable tradition of care and service that should not lightly be discarded. Consequently we were tempted to advocate the retention of the term "cottage hospital", but we think that the term Community Nursing Unit more adequately describes the function of the sort of place that we have in mind.

195. Although some cottage hospitals might provide the base for nursing units and headquarters for the group practice team, we can also see the need for experiments in the provision of similar beds in purpose-built premises in close proximity to group practice centres. The establishment of nursing units in close proximity to group practice centres, as at Hythe (Hants) and Witney, might become the

pattern of the future, with the advantage that the nurses of a group practice, supplemented by some others, could undertake the care of patients there.

District Hospital Beds

196. Some general practitioners have expressed the desire to undertake the entire clinical control of their patients in the district general hospital. Even if this expressed need could be fulfilled by the hospital services it seems unlikely for various reasons that many general practitioners could undertake this responsibility adequately. Ready availability and provision of adequate deputies are implict in providing such care. It would be unusual for many general practitioners to be so fortunately placed and, even if they were, it is unlikely that they could give adequate total patient care without a large measure of involvement of the full-time junior hospital medical staff.

197. There is quite a different contribution which general practitioners can now, and will probably increasingly wish to make to the hospital service: participation in hospital work as a member of the hospital team. Here the final responsibility lies with the consultant while the continuity of care is provided by the team. General practitioners living many miles from a hospital undertake work of this kind on a sessional basis. The mutual benefit to all concerned of this kind of arrangement is already so well established that it is clear that progress along this line must continue.

198. The need of general practitioners for direct access to obstetric beds has been increasing over the years and has, to a varying extent, been met by the provision of general practitioner obstetric units. The Peel report (11), on the future of domiciliary midwifery, has recommended that 100 per cent hospital delivery should be aimed for, although recognising that this cannot be wholly achieved. It also stated that, in the future, only those general practitioners specially trained in midwifery should take part in the domiciliary midwifery service and should use beds in general practitioner/consultant obstetrics units. If these proposals are adopted it would mean the eventual closure of those general practitioner obstetric units not conjoined with consultant obstetric services. The arguments for and against such proposals are outside the context of these paragraphs, but it is relevant to emphasise that, should the recommendations of the Peel report be adopted, then more general practitioner obstetric beds will have to be provided in the joint general practitioner/consultant units which are envisaged to be sited in the district general hospitals of the future.

199. There is little information regarding the need for general practitioners to have direct access to beds for the long stay chronic sick. Where he does have such access, the beds are usually associated with cottage hospitals where the whole of the medical staff is drawn from the local general practitioners. It seems unlikely that well-organised in-patient geriatric services provided in large conurbations would benefit by having some of their patients admitted directly, and cared for by the patient's own general practitioner, and we received little evidence that general practitioners as a whole feel a great need for this facility. As with beds for obstetrics and acute medical care, general practitioners who undertake this work, should do so as clinical assistants and as an integral part of the geriatric team. Ideally, as in obstetrics, each group practice will have a doctor whose special

interest lies in the field of geriatric medicine and rehabilitation. In this way continuity of care by group practice can be maintained.

200. For obvious reasons the precise need and location of the beds referred to in the preceding paragraphs will vary from area to area. There is also a need to experiment with different methods of providing the nursing care in the community that will avoid the admission to the District General Hospital of some patients.

Out-Patients

201. Amongst the traditional features of the hospital which require reappraisal, is the out-patients department. Usually out-patients departments are situated in or adjacent to the hospital. Normally they do not provide primary medical care (except in such departments as venereology), but give a consultant service, both diagnostic and follow-up, to patients referred by general practitioners. In their survey "Gateway or Dividing Line" (42), Logan and Forsyth found that in many specialties, relatively few people seen as out-patients were, as a result, ever admitted to hospital, although the percentage so admitted was high in ear, nose and throat surgery, and gynaecology. They also found that only a small proportion of patients had any pathological or radiological examination after their first attendance at the out-patient department. These authors argued that since, in the main, the out-patients department gave a consultant service for general practitioners rather than constituting a gateway into hospital, then it could be questioned whether it was necessary for out-patient consultations to be held adjacent to the hospital wards. It was suggested that it would be more logical for consultants to hold out-patient sessions in a health centre or group practice. There is nothing new in the idea of holding out-patient sessions at a distance from the hospital ward; many chest clinics work in such a way and for many years the general out-patient department of the United Sheffield Hospitals has been conducted at the, as yet embryonic, new teaching hospital—the Hallamshire Hospital—the wards of which are still being completed. Also, many consultants conduct out-patient clinics in cottage hospitals to whose wards they have no admission rights. What is novel, is the suggestion that certain consultant out-patients sessions should be held in premises clearly within the ambit of the community medical services, be it group practice premises or a health centre. In terms of inter-personnel contact such schemes would undoubtedly help to strengthen the links between those who work for the health of the community within the hospital and outside.

202. The holding of consultative clinics in group practice centres has been enthusiastically advocated by Draper (17). The Bonham-Carter report (39), although more guarded, did agree that this possibility should be considered. The need for peripheral clinics or diagnostic centres, where consultations can be undertaken locally, was expressed in the Hospital Plan of 1962, but the implication was that such centres should be an extension of the hospital rather than being within premises which are primarily community orientated. The advantages of holding consultative sessions in group practice centres are numerous:

(i) Patients would be able to receive specialist advice in the same place at which were concentrated the other community medical services. This would be not only convenient for the patients but also reassuring, since the consultation would occur in a setting already familiar to them.

(ii) The necessary personal contact would be promoted between hospital and community personnel at the most logical time, that is at the time of referral.
(iii) By such contact the two groups of people would have a greater understanding of each other's problems with opportunities for mutual education and professional improvement.
(iv) The theme of continuity and interdependence within the health service would be fostered.
(v) The close collaboration between the consultant and the general practitioner, which has been shown to be so necessary if schemes for day surgery or short stay medical treatment are to be successful, would be ensured.

The disadvantages would include:

(i) The need, initially at least, to persuade hospital personnel of the advantages of such schemes that go against accepted hospital out-patient tradition.
(ii) The possible charge that it would lead to dispersal of consultants' time and effort.
(iii) The fact that many consultants consider that out-patient consultative clinics involve not only the consultant but other members of the medical or surgical team. In these circumstances it would be impractical for the team as a whole to be outside the hospital, since it is desirable especially for middle and junior grades of hospital medical staff to be available within the hospital to meet the contingencies of everyday hospital work. The increasing complexity and intensification of hospital work is likely to increase the need for those possessing high skills to be available at short notice.
(iv) The argument that the introduction of community-based consultative services would necessitate an increase in hospital medical staff of all grades, especially of consultant grade.
(v) The widely held view, supported by the Bonham-Carter report, that consultants' time is better used when concentrated in one locus of activity.

203. In considering these advantages and disadvantages, we have had little help from those with practical experience of such types of consultation because so few schemes are in operation. Those who have described their experiences have been enthusiastic. In particular, Wade and Elmes (1969) (46) have demonstrated that out-patients sessions conducted in a health centre save the patient as much as two visits to the hospital; that the time taken over a consultation is significantly reduced; and that most of the investigations which were necessary could be arranged by the general practitioner before the consultation took place, provided he had access to these facilities. On balance, we feel that the advantages outweigh the disadvantages and recommend that, initially at least, pilot schemes of community-based consultative clinics should be established. The experience gained from these should lead to a better appraisal of their worth and give a lead to future policy. The most suitable specialties would be general medicine, dermatology, psychiatry, paediatrics, obstetrics and some aspects of geriatrics.

204. Many hospitals have provided primary medical care to patients through the medium of the accident and emergency departments. The patients attending

these departments suffer from a variety of conditions. We think that a distinction should be made between emergencies and casual attenders. The former require the skills of the staff within hospital units, whereas the latter are best dealt with by the person's general practitioner or his deputy who should have the benefit of the patient's past history. We do not think that these functions can be provided by a single service staffed either by hospital doctors or by general practitioners except possibly in rural areas. Our concept of the optimum size of a group practice takes in to account the need to provide a 24-hour service without placing too heavy a load on any single doctor. Traditionally, patients, for various reasons, still turn to the casualty department of the local hospital as an alternative to consulting their family doctor. "Casualty" departments are used by patients who find themselves in sudden need of medical care when far from home and the family doctor —they consider this to be a genuine emergency and therefore are something more than casual "attenders". Similarly the patient who suffers an injury will want to call first on the accident department of the hospital. We feel there is still a place for the accident and emergency departments to continue to accept the "casual" patients (if only to refer him, after examination, to his own general practitioner) and it will require a great deal of education to reorientate these patients towards primary consultation with their own general practitioner. In such a department there may well be a place for the general practitioner in the staffing of the hospital and this problem, which falls outside our remit, merits further consideration. Another solution would be to provide these facilities in health centres, particularly in those within the curtilage of the hospital.

205. We accept the recommendations of the Platt Report, many of which have not been implemented. It recommended the concentration of accident services for an area in one place, provided that efficient transport service could be arranged. The report recognised, however, that in some rural areas there would still remain a need for more sophisticated first aid before transport to a more distant accident centre and suggested that facilities for this could best be placed in existing cottage hospitals.

Communication between the Hospital and Group Practice

206. We would particularly emphasise one more aspect of the changes that command our support. At present about one quarter of general practitioners have an intimate contact with hospitals by playing some part in hospital work. In future, we believe that many more will be involved in one aspect or another of it, accompanied by a considerable increase in the readiness with which consultants come out of their hospitals to consult with their colleagues in general practice, not only under the domiciliary consultation scheme, but also to hold consultative sessions in group practice centres.

207. The first twenty years of the National Health Service have had the effect of separating general practitioners from their hospital colleagues. We see an opportunity to reverse that unfortunate trend. This is an opportunity that must be taken, for doctors, patients, nurses and associated workers have much to gain from closer integration.

208. An important part of the relationship between hospitals and group practices lies in aftercare. Not far short of 10 per cent of our population are admitted to hospital each year, and the effectiveness of the management of this large number

of patients subsequent to discharge is dependent on the quality of communication between the hospital staff and general practitioners. For many of the commoner causes of admission there may be little to convey which is not already well understood by all those caring for the patient, but even with these there may be occasions, such as the introduction of early discharge schemes, when the hospital policy should be discussed with the general practitioner. At the other extreme, there are conditions in which the plan of management initiated in hospital can realise its potential after discharge only if the general practitioner is fully aware of the aims and methods of the hospital, or where the consultant needs the general practitioner's guidance in determining what long-term plan is best suited to the particular patient. The care of chronic illness ranging from congenital deformities in infants to strokes in the elderly demands such close identity of purpose that without it the patient may suffer.

209. Poor communication between the hospital and the general practitioner may not only be to the detriment of the patient, but may encourage hospitals to continue responsibility for patients long after this should have been handed back to the general practitioner; we have referred to this inefficient use of the Health Service in Chapter I, paragraph 3.

210. There is no single way of achieving the close relationship between hospital and general practitioner that is required. We have indicated in this and in other chapters of our report ways in which group and health centre practice can encourage the necessary exchange of ideas, for example by the conduct of outpatient clinics in the health centre and by the greater facility for some of the doctors in the group to hold hospital appointments on a sessional basis. In some of the more complicated problems of long-term care the community physician could play a large part in co-ordinating the efforts of the hospital and the general practitioner on the patients' behalf, and he could perform this role more effectively in group practice. Above all, because of the natural exchange of ideas and information which must take place between doctors working together in a group practice, communication between a hospital department and any one of them can have a wider audience within the group practice team and thereby gain in effect.

CHAPTER XII

THE ROLE OF GROUP PRACTICE IN EDUCATION

211. Throughout our report we have assumed that adequate educational facilities will exist in order to train doctors to undertake the role that we envisage for them in the future. We are well aware that such facilities do not exist in most parts of the country at the moment and that, where they do exist, they are at an early stage of development. It would, as we have said before, be a mistake to plan our health services upon the basis of the present abilities of our doctors, because this will inhibit progress. Any interim arrangements must be recognised as being purely temporary and steps must be taken to remedy the educational deficiencies as a matter of urgency. Information should be collected, and kept under constant review, about the way in which the range and extent of current ideas on teaching, about and in general practice, match and progress to meet the foreseen changes, including the need for new skills and developments in the disciplines of psychology and sociology.

212. Some group practices will have a role to play in education. As the Royal Commission on Medical Education (8) recommended, every medical student needs to be given an insight into general practice, not as a preliminary to training for a career in that field, but as an educational experience to show him problems he will not see in hospital. It will be essential to introduce the medical student to general practice and community medicine if we are to achieve a real degree of functional unification of our health services. In an age of increasing specialisation, functional unification can only be realised if a doctor in one specialty is able to appreciate the roles of doctors in other fields of work.

213. There is general agreement that young doctors who wish to make a career of general practice should undertake a period of planned vocational training. A Working Party of the Royal College of General Practitioners has suggested the outlines of a Syllabus for training in general practice (Appendix D). The extent of the period of vocational training cannot be exactly defined until this syllabus, and the results of a number of experiments now taking place, have been considered. We are convinced that, in the future, vocational training should become an accepted prerequisite for new entrants to general practice, and that some form of assessment of the training will be required.

214. The fear has been expressed that prolonged professional training for general practice might adversely affect recruitment to this branch of the profession. We agree with the views expressed by the Royal Commission on Medical Education that more training will attract rather than deter young doctors from choosing general practice. We further concur with the statement of the British Medical Association Planning Unit that when a young doctor enters general practice and finds himself confronted with problems which he has not been trained to meet it is understandable that he should feel frustrated.

215. The universities and medical schools must, for obvious reasons, be responsible for undergraduate training in all disciplines of medicine. In most medical schools the training of the undergraduate still takes place almost entirely within the confines of the teaching hospital, and it is only recently that some universities have begun to take an interest in the postgraduate training of doctors who will be working outside the hospital. The Royal College of General Practitioners must take considerable credit for the progress that has been achieved in persuading universities to interest themselves in the education of the general practitioner. The exposure of the undergraduate to medicine outside the hospital can only be accomplished if there are strong and active departments of social medicine and general practice within the medical schools. These departments could together form a division of community medicine.

216. Some medical schools are experimenting with methods of introducing undergraduates to medicine outside the hospital. Unless it can demonstrate this in the service situation, a department of general practice cannot fulfil its role. The vocational training of general practitioners must look to the future of primary medical care rather than to present day general practice. For these reasons the department of general practice should be based upon a group practice centre in close association with the teaching hospital, and we recommend that those practices which are the focus of the department of general practice should combine the functions of service with those of teaching and research. Amongst other activities such centres should experiment with carefully selected alternative methods of providing primary medical care. The results of these studies would enable policy decisions to be based on satisfactory data.

217. A department of general practice in a medical school will be unable to provide all the requirements of both undergraduate and postgraduate teaching. There will consequently be the need for a number of teaching practices which should be associated with the department of general practice. These practices will be involved in the teaching of undergraduates, including the teaching of those who choose general practice for their elective period, as well as those linked to selected general practitioners under a university attachment scheme. In the postgraduate phase general practitioners will be needed to take part in the vocational training programme.

218. The teaching practices referred to in the preceding paragraph will need to be carefully chosen and supervised, and must accept the need for periodic review of their premises and programmes. We recommend that this should be the responsibility either of the universities or of the Regional Postgraduate Committees. Teachers in these practices will have to be instructed in teaching methods, and additional staff, accommodation and finance will be necessary.

219. In this chapter we have concentrated on the educational requirements of the doctor. It must be obvious, however, that the group practice will have a part to play in the training of nurses, health visitors, social workers and of student medical secretaries and receptionists. It would be logical if these teaching requirements were to be undertaken within the same practices that were involved in the training of doctors.

220. It is obvious that in any consideration of health centres and group practices of the future the role of some of these as teaching centres must be accepted, and the requirements of teaching in terms of accommodation, equipment, personnel

and finance must be catered for. A consulting suite will be required for vocational trainees and there must be at least one room set aside for personal study and individual teaching. If undergraduates are also to be attached they too will require separate accommodation for personal study. We recommend that the Common Room/Staff Room be of a sufficient size to enable seminars and other forms of group discussions to take place. It will be necessary also to provide additional accommodation or space for nurses, health visitors, social workers and receptionists if any of these have students attached to them.

221. No recognition appears to have been given so far to the educational function of group practice in the building of the premises. This is short-sighted and likely to inhibit the future development of group practice. We noticed with some disquiet that in not one of the health centres we visited was there any accommodation available specifically for teaching. Whilst in some it might have been possible to make space for an extra chair in existing consulting rooms, in most this seemed as far as the building could have been adapted for teaching purposes. Consequently, this function can only be catered for in the future by building on to existing premises. We have, in Chapter VI, mentioned the need to allow for the extension of health centres. This will be especially important in view of the additional space required for teaching.

The Staff of Teaching Group Practices

222. We believe that it should be the responsibility of the Health Departments, and not the individual general practitioners, to provide for the additional accommodation and equipment that may be required for teaching purposes.

223. It is important that medical students and trainee general practitioners should be the responsibility of a particular doctor who would act as a tutor; this may take up a significant amount of time. Nevertheless, the other doctors in the group should also take part in teaching and will, in all probability, also be involved, from time to time, in teaching activities in the university Department of General Practice, or in a postgraduate medical centre. It is clear from the above that considerable inroads will be made into the time of at least one doctor in the centre or group practice and will cause some pressure on all the others. We must, therefore, acknowledge that if the teaching role is to be assumed by practising doctors, extra time will have to be found.

224. Doctors and nurses within each group practice should organise their own continuing education which would complement that provided at postgraduate medical centres.

CHAPTER XIII

THE OPPORTUNITY FOR RESEARCH IN GROUP PRACTICE

225. In the introduction to our report we stated that whilst we received a wealth of informed opinion, there was a notable lack of concrete evidence. Throughout our report we have drawn attention to a number of instances where there is a need for research. In general, we think that traditional methods for providing medical services are being continued without any critical assessment of their current value: studies are being undertaken both in the hospital services and in the community services but little attention is being devoted to experiments designed to integrate the two services; buildings are being constructed without any subsequent continous evaluation of the use to which they are put; the results of experiments are in some instances not being applied. It is important that there should be a cost benefit basis for studies of the National Health Service and, in particular, for the provision of care in both the community and the hospital.

226. It is most important that studies should be mounted to evaluate group practice as it develops including the operation of health centres. We would draw attention to the design in use studies at health centres being undertaken by the Department of Health in Northern Ireland.

227. We know the Health Departments have been encouraging and supporting research along these lines. The Departments in the future should be responsible for stimulating, co-ordinating and providing facilities for research which should be an integral function of each area health authority or whatever local organisation that emerges. The Health Departments should also undertake the task of correlating and disseminating the results of studies undertaken throughout the country.

228. It is important that the universities and medical schools should devote more time than they have in the past to research into the medical needs of the community and how they may be met. The departments of Social Medicine and General Practice in particular will be in a position to provide a great deal of assistance to the community physician in the planning and conduct of the sort of operational research to which we have referred in the preceding paragraphs.

229. An increasing proportion of medical research has been devoted to the investigation of disease in population groups and into the early stages and natural history of disease. Much of this type of work, which is essentially of an epidemiological nature, can and should be done through group practice. The Royal College of General Practitioners through its Research Committee, departments of General Practice and departments of Social Medicine in universities, together with the community physician, are likely to have a major role to play in this field.

230. Much clinical research starts at the bedside of the patient. There are consequently great opportunities for this type of research in general practice. The value of this research is enhanced by the continuing nature of the relationship between the doctor and the patient extending, in some cases, from birth to death.

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APPENDIX B

HEALTH CENTRES AND GROUP PRACTICES VISITED BY MEMBERS OF THE SUB-COMMITTEE

St. George's Health Centre (Bristol)
Stockwood Health Centre (Bristol)
William Budd Health Centre (Bristol)
Ashburton Health Centre (Devon)
Exeter Health Centre (Devon)
Ivybridge Health Centre (Devon)
Salcombe Health Centre (Devon)
Hythe Health Centre (Hampshire)
Risca Health Centre (Monmouthshire)
East Leake Health Centre (Nottinghamshire)
Mansfield Health Centre (Nottinghamshire)
Blackbird Leys Health Centre (Oxford)
East Oxford Health Centre (Oxford)
Summertown Health Centre (Oxford)
Cleckheaton Health Centre (West Riding of Yorkshire)
Emley Mini Clinic (West Riding of Yorkshire)
Holmfirth Health Centre (West Riding of Yorkshire)
Ilkley Health Centre (West Riding of Yorkshire)
Kirkburton Clinic (West Riding of Yorkshire)
Middlestown Health Centre (West Riding of Yorkshire)

Dr. D. I. Livingstone and Partners (Cheshire)
Dr. R. A. Lutton and Partners (Cheshire)
Dr. J. Loudon and Partners (Cumberland)
Dr. D. F. Coulter and Partners (Glamorgan)
Dr. C. K. B. Lennox and Partners (Glamorgan)
Dr. D. A. Chandler and Partners (Herefordshire)
Dr. D. D. Cracknell and Partners (Huntingdon)
Dr. G. Christie and Partners (Manchester)
Dr. B. Burns and Partners (Sheffield)
Dr. P. King and Partner (Shropshire)
Dr. A. Sherlock and Partners (Suffolk)
Dr. W. T. Mills and Partners (Wiltshire)
Dr. F. C. Heatley and Partners (Winchester)

APPENDIX C

LIST OF ORGANISATIONS AND INDIVIDUALS WHO SUBMITTED EVIDENCE TO THE SUB-COMMITTEE

Those who gave oral evidence only are marked *; those who gave both oral and written evidence are marked†; the others gave written evidence only.

Doctors R. A. Andrew, H. P. Player and I. A. D. Jollie
Association of Medical Secretaries
Association of Municipal Corporations
Association of Psychiatric Social Workers
Dr. P. Aston
G. Baxter Esq. (Chemist)
Birmingham Medical School
British Dental Association
†British Medical Association: Central Committee for Hospital Medical Services
†British Medical Association: General Medical Services Committee
British Medical Association: Public Health Committee
Doctors D. L. Broadhead, A. O. Russell, J. H. T. Shaw and B. S. Milner
Dr. M. Z. Butt
Central Committee on Postgraduate Medical Education of Physicians
Central N.H.S. (Chemists Contractors) Committee
Charing Cross Hospital Medical School
Cheshire N.H.S. Executive Council
Dr. F. S. Cooksey C.B.E.
Council for the training in Social Work
Council for the training of Health Visitors
County Councils Association
Dr. D. L. Crombie
Dr. P. J. Cutler
Dr. G. A. N. Davis
†Dr. P. Draper and B. Brookes Esq.
Dr. M. Drury
Executive Councils Association (England)
Faculty of Radiologists
*Dr. B. E. Finch
Dr. C. B. Floyd
General Nursing Council for England and Wales
General Practitioners' Association
Dr. Mervyn Goodman
Guy's Hospital Medical School
Dr. F. G. Hattersley
†Health Visitors' Association
Dr. M. I. Heatley
Dr. P. Higgins
Dr. S. Higham
Mrs. M. Hitchins
Inner London Local Medical Committee
Institute of Laryngology and Otology
Institute of Medical Social Workers
Institute of Neurology

Dr. Donald H. Irvine
Dr. M. J. Jameson
Dr. Robert A. Johnson, B.A. (Cantab.)
Dr. P. Jones
Kingston-upon-Hull Local Medical Committee
Kinloch and Anderson (Chemists) Ltd.
Doctors I. M. Krass, S. A. Holmested and M. M. Sabir
Lancashire County Local Medical Committee
Dr. John Leiper M.B.E., T.D.
Dr. M. Macleod
Dr. R. A. McGregor
Medical Practitioners' Union
Doctors G. H. Miles, D. K. W. Bolt and I. M. Hadley
Ministry of Health and Social Services, Northern Ireland
M. J. Moon Esq. (Chemist)
Dr. G. Murray Jones, M.B.E.
National Association of State Enrolled Nurses
National Institute for Social Work Training
*Dr. J. H. Orr
*Doctors R. W. Orton, W. Dobson-Smyth, C. A. Bickford, P. E. Moffitt and T. J. Willis
Dr. E. J. Parr
Patients' Association
†Pharmaceutical Society
Dr. D. Pottinger
Pre-School Play Groups Association
†Queen's Institute of District Nursing
Queen's University of Belfast
†Royal College of General Practitioners
Royal College of Midwives
†Royal College of Nursing
Royal College of Pathologists
Royal Post-Graduate Medical School
St. George's Hospital Medical School
St. Thomas's Hospital Medical School
†Society of Chief Nursing Officers
Society of Chiropodists
Society of Clerks of N.H.S. Executive Councils
†Society of Medical Officers of Health
Society of Medical Officers of Health—Dental Group
Society of Occupational Medicine
Dr. F. H. Staines
*Standing Conference of Organisations of Social Workers
T. W. Stearne Esq. (Pharmacist)
Dr. Robin Steel
Trades Union Congress
University College Hospital
University Hospital for Wales Dental School
University of Liverpool Medical School
University of Newcastle upon Tyne Medical School
University of Oxford Medical School
University of Sheffield
Warwickshire County Council
Welsh Board of Health (Now Welsh Office)
Welsh National School of Medicine
Dr. D. L. Williams
Dr. H. J. Wright

APPENDIX D

SYLLABUS FOR TRAINING IN GENERAL PRACTICE (SUGGESTED BY A WORKING PARTY OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS)

Area I. Clinical Medicine

Appropriate expertise in traditional specialties, emphasising general medicine, and with special reference to:

(*a*) The range of the "normal".

(*b*) The patterns of illness.

(*c*) The natural history of diseases.

(*d*) Prevention.

(*e*) Early diagnosis.

(*f*) Diagnostic methods and techniques.

(*g*) Management and treatment.

In the next three areas—human development, human behaviour, society and medicine—older doctors had little or no grounding as undergraduates. They do form part of undergraduate medical education today but their relevance to general practice warrants their further study.

Area II. Human Development

(*a*) Genetics.

(*b*) Foetal development.

(*c*) Physical development in childhood, maturity and ageing.

(*d*) Intellectual development in childhood, maturity and ageing.

(*e*) Emotional development in childhood, maturity and ageing.

(*f*) The range of the "normal".

Area III. Human Behaviour

(*a*) Social relationships—between individuals, within families, in school, at work, in other groups, and in the wider community.

(*b*) The individual or family vulnerable because of medical or social situations, acute or chronic.

(*c*) The meaning to the patient of his relationship and consultations with his general practitioner.

(*d*) The general practitioner's role in accepting, understanding and advising on deviant behaviour patterns.

Area IV. Society and Medicine

(*a*) The meanings of "health" and "illness".

(*b*) The relationship of medical services to other institutions of society.

(*c*) The application of sociological and epidemiological principles to individuals and the practice community.

(*d*) Interprofessional relationships in teamwork and consultation, delegation and referral.

(*e*) The organisation of medical services in the United Kingdom, and comparison with those of other countries.

AREA V. THE PRACTICE

(*a*) Organisation.

(*b*) Premises, staffing and equipment.

(*c*) Recording and communications.

(*d*) Practice management.

(*e*) Research methods.

APPENDIX E
ESSENTIAL PERSONAL MEDICAL RECORD CARD

ESSENTIAL PERSONAL MEDICAL RECORD

N ——————— NI No. ———————

D o B ——————— Add ———————

———————

N o K ——————— Add ———————

———————

Dr ——————— Phone No ———————

Transplant Organ Donor, Yes/No. S. ———————

P.T.O.

DATE	DETAILS

If a personal medical record card is used to note only essential information it need be no larger than 5″ × 3″. To save space it need bear no instructions for completion, for it will become so familiar that instructions would hardly be necessary except, perhaps, on the package containing a stock of cards.

Abbreviations used are "N" = name, "NI No." = National Insurance No., "Add" = address, "D o B" = date of birth, "N o K" = next of kin, "Dr" = name of GP, and his telephone number, "Transplant Organ Donor, Yes/No" = whether or not the person is willing for his organs to be used after death for transplant purposes, "S" = signature.

The back of the card needs ruling for date and details. Here, only essential information should be given.

A haemophiliac would record the diagnosis, his blood group and, perhaps, the hospital address of the Haemophiliac Centre at which he is registered.

A diabetic would state the fact, the type of insulin, the address of the Diabetic Clinic he attends regularly.

A professional footballer might record when he last had a tetanus booster injection.

A man who had suffered coronary thrombosis would state the fact, the date and whether or not he was receiving anticoagulant therapy.

It is not expected that the card would last a lifetime nor that a card would supply anything like a complete medical history, but in an emergency it would be a useful warning that further information was required and would be sufficient for initial treatment to be undertaken.

APPENDIX F

TABLE 1

Practice structure of principals providing unrestricted general medical services: 1952 to 1969
(Figures abstracted from the annual reports of the Department of Health)

	Number and proportion of principals practising													
			In partnerships of											
	Single-handed		2		3		4		5		6 or more		Total	
Year*	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1952	7,459	43·6	5,732	33·0	2,577	15·0	960	5·7	315	1·6	161	1·1	17,204	100
1953	7,147	39·7	6,146	34·1	2,898	16·1	1,168	6·5	410	2·3	241	1·3	18,010	100
1954	6,899	37·3	6,414	34·7	3,129	16·9	1,308	7·1	445	2·4	287	1·6	18,482	100
1955	6,715	35·7	6,628	35·3	3,246	17·3	1,440	7·7	465	2·5	289	1·5	18,783	100
1956	6,568	34·4	6,728	35·3	3,465	18·2	1,528	8·0	460	2·4	333	1·7	19,082	100
1957	6,381	33·0	6,848	35·4	3,609	18·7	1,608	8·3	545	2·8	352	1·8	19,343	100
1958	6,346	32·4	6,916	35·3	3,705	18·9	1,712	8·7	525	2·7	395	2·0	19,599	100
1959	6,119	31·2	6,972	35·7	3,789	19·5	1,808	9·3	565	3·3	401	2·0	19,654	100
1960	5,897	29·7	6,906	34·8	4,107	20·7	1,856	9·4	640	3·2	427	2·2	19,833	100
1961	5,598	27·8	6,860	34·2	4,311	21·4	2,120	10·5	750	3·7	468	2·4	20,107	100
1962	5,422	26·8	6,674	32·9	4,581	22·6	2,228	11·0	820	4·0	542	2·7	20,267	100
1963	5,208	25·7	6,668	32·8	4,728	23·3	2,180	10·7	865	4·3	646	3·2	20,295	100
1964	5,000	24·7	6,616	32·8	4,749	25·5	2,376	11·8	855	4·2	600	3·0	20,196	100
1965	4,838	24·2	6,368	31·9	4,767	23·9	2,440	12·2	930	4·6	633	3·2	19,976	100
1966	4,754	24·0	6,146	31·1	4,761	24·0	2,556	12·9	895	4·5	690	3·5	19,802	100
1967	4,646	23·5	5,700	28·8	4,923	24·9	2,860	14·4	925	4·6	755	3·8	19,809	100
1968	4,512	22·7	5,448	27·3	5,067	25·4	2,864	14·4	1205	6·0	838	4·2	19,934	100
1969	4,331	21·6	5,156	25·7	5,250	26·1	3,084	15·3	1345	6·7	928	4·6	20,094	100

*At 1 October

TABLE 1A

Change in practice structure: 1954–1969. England and Wales

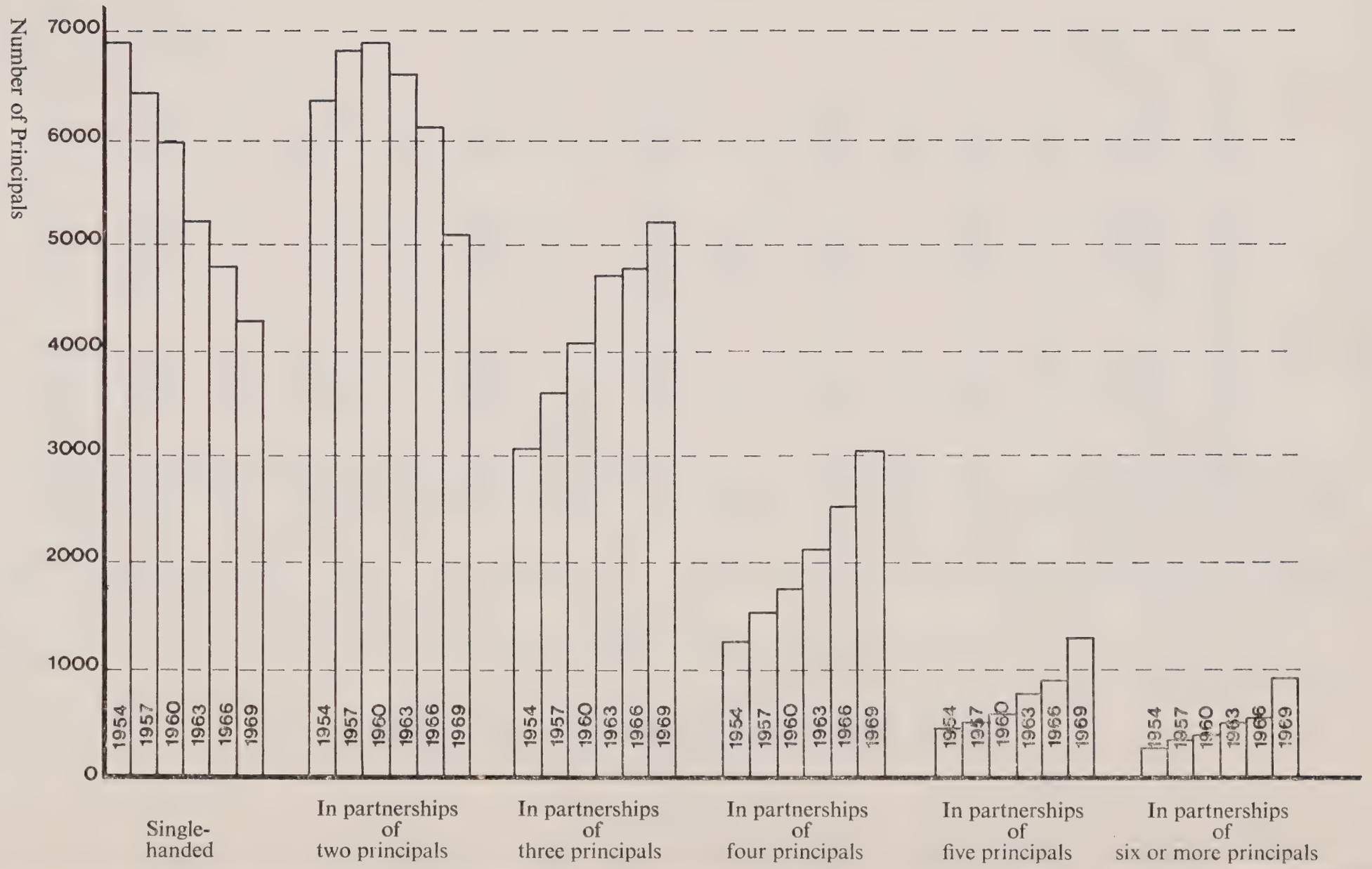

TABLE 2

Group practices in England and Wales at 1st October 1969

Number of group practices analysed by the number of principals in each group

Number of principals in the group practice	England and Wales		England		Wales	
	Number of group practices	Number of partici-pating principals	Number of group practices	Number of partici-pating principles	Number of group practices	Number of partici-pating principals
All practices: Total	3,054	10,555*	2,854	9,867*	200	688*
2 principals	322	640	313	622	9	18
3 principals	1,620	4,860	1,500	4,500	120	360
4 principals	722	2,888	670	2,680	52	208
5 principals	253	1,265	241	1,205	12	60
6 principals	98	588	91	546	7	42
7 principals	19	133	19	133	—	—
8 principals	11	88	11	88	—	—
9 principals	3	27	3	27	—	—
10 principals	3	30	3	30	—	—
11 principals	2	22	2	22	—	—
12 principals	—	—	—	—	—	—
13 principals	—	—	—	—	—	—
14 principals	1	14	1	14	—	—

*Owing to unfilled vacancies the numbers of participating principals shown may be less than the product of the number of group practices multiplied by the number of principals in the group.

TABLE 3

Health centres in England and Wales, position at 31 December, 1969

	Total*		Type of Authority		
			County Councils	County Boroughs	London Boroughs
In operation and first opened:					
Before 1948†	10	(5)	6	1	3
1948†–1963	17	(0)	4	10	3
1964–1967	27	(4)	16	9	2
1968	40	(4)	29	7	4
1969	55	(5)	43	9	3
Total	149	(18)	98	36	15
Being built	94	(15)	57	27	10
Approved	77	(3)	55	15	7
Total	320	(36)	210	78	32

*Figures in brackets are for Wales; all but seven of these are under County Councils.
†July, 1948.

TABLE 4

Numbers of general practitioners practising in health centres, position at 31 December, 1969, England and Wales

	Number of Centres*	Total number of G.P.s	G.P.s per centre		Proportion of G.P.s using centres as main surgery (%)
			Average	Range	
In operation and first opened:					
Before 1948†	7	31	4·4	2–10	100
1948†–1963	16	185	11·6	3–26	14
1964–1967	27	115	4·3	1–10	86
1968	40	172	4·3	1–16	84
1969	55	257	4·7	1–15	82
Total	145	760	5·2	1–26	68
Being built	94	566	6·0	1–19	83
Approved	77	437	5·7	2–21	89
Total	316	1763	5·6	1–26	78

*Excluding the four centres with no general practitioners, built before 1964.
†July, 1948.

TABLE 5

Number of health centres* in operation at 31 December, 1969, analysed by geographical location

Region and Executive Council	Number of health centres	Number of doctors	% of all doctors in area
North Region			
Cumberland	—	—	—
Carlisle	—	—	—
Durham	4	32	10·9
Darlington	—	—	—
Gateshead	—	—	—
Hartlepool	—	—	—
South Shields	—	—	—
Sunderland	3	21	26·9
Northumberland	1	2	1·0
Newcastle upon Tyne	—	—	—
Tynemouth	—	—	—
Westmorland	—	—	—
Yorks N Riding	1	3	2·2
Teesside	2	27	18·5
Total: North Region	11	85	6·5
Yorkshire and Humberside Region			
Lincs Lindsey	4	12	7·7
Grimsby	—	—	—
Yorks E Riding	—	—	—
Kingston upon Hull	—	—	—
Yorks W Riding	13	58	8·7
Barnsley	—	—	—
Bradford	—	—	—
Dewsbury	—	—	—
Doncaster	—	—	—
Halifax	—	—	—
Huddersfield	—	—	—
Leeds	—	—	—
Rotherham	—	—	—
Sheffield	1	3	1·4
Wakefield	—	—	—
York	1	1	3·3
Total: Yorkshire and Humberside Region	19	75	3·9
East Midland Region			
Derbyshire	—	—	—
Derby	—	—	—
Leicestershire and Rutland	—	—	—
Leicester	—	—	—
Lincs Holland	—	—	—
Lincs Kesteven	—	—	—
Lincoln	—	—	—
Northants	2	11	9·0
Northampton	—	—	—
Notts County and City	5	34	9·5
Total East Midland Region	7	45	3·4
East Anglia Region			
Cambs and Isle of Ely	4	16	12·2
Hunts and Peterborough			
Norfolk	—	—	—
Great Yarmouth	—	—	—
Norwich	—	—	—
Suffolk East	—	—	—
Ipswich	—	—	—
Suffolk West	—	—	—
Total: East Anglia Region	4	16	2·3
South West Region			
Cornwall	1	4	2·2
Devon and Exeter	23	76	24·3
Plymouth	—	—	—
Dorset	—	—	—
Gloucester C and City	3	34	12·1
Bristol	4	31	16·5
Isles of Scilly	1	1	50·0
Somerset	3	13	5·1
Bath	—	—	—
Wiltshire	1	10	5·3
Total: South West Region	36	169	9·8

TABLE 5—*continued*

Region and Executive Council	Number of health centres	Number of doctors	% of all doctors in area
South East Region			
Bedfordshire & Luton	1	3	1·7
Berkshire	1	3	1·5
Reading	—	—	—
Buckingham-shire	1	2	0·9
Essex	1	4	0·9
Southend-on-Sea	—	—	—
Hampshire	2	25	6·3
Bournemouth	—	—	—
Portsmouth	—	—	—
Southampton	—	—	—
Hertfordshire	2	8	2·2
Isle of Wight	—	—	—
London Inner	6	10	0·7
London N.E.	3	17	3·6
London S.E. and Kent	1	3	0·4
London S.W. Surrey	4	24	2·8
Middlesex	4	21	2·3
Oxford County & City	4	23	15·0
Sussex East	1	6	3·1
Brighton	—	—	—
Eastbourne	—	—	—
Hastings	—	—	—
Sussex West	—	—	—
Total: South East Region	31	149	2·0
West Midland Region			
Herefordshire	1	4	6·2
Salop	—	—	—
Staffordshire	2	16	6·8
Burton-upon-Trent	—	—	—
Stoke-on-Trent	4	36	34·0
Walsall	—	—	—
Warley	—	—	—
West Bromwich	—	—	—
Wolverhampton	—	—	—
Warwickshire & Solihull	—	—	—
Birmingham	3	14	3·1
Coventry	1	9	6·9
Worcestershire	—	—	—
Dudley	—	—	—
Worcester	—	—	—
Total: West Midland Region	11	79	4·0

Region and Executive Council	Number of health centres	Number of doctors	% of all doctors in area
North West Region			
Cheshire	3	7	1·7
Birkenhead	—	—	—
Chester	—	—	—
Stockport	—	—	—
Wallasey	—	—	—
Lancashire	2	12	1·4
Barrow-in-Furness	—	—	—
Blackburn	2	18	46·2
Blackpool	—	—	—
Bolton	2	7	11·1
Bootle	—	—	—
Burnley	—	—	—
Bury	—	—	—
Liverpool	1	8	2·9
Manchester	—	—	—
Oldham	—	—	—
Preston	—	—	—
Rochdale	—	—	—
St Helen's	—	—	—
Salford	—	—	—
Southport	—	—	—
Warrington	1	18	47·4
Wigan	—	—	—
Total: North West Region	12	70	2·7
Wales			
Anglesey	1	2	7·4
Breconshire	—	—	—
Caernarvon-shire	—	—	—
Cardiganshire	—	—	—
Carmarthen-shire	1	2	2·4
Denbighshire & Flintshire	—	—	—
Glamorgan	5	17	5·6
Cardiff	2	9	6·4
Merthyr Tydfil	—	—	—
Swansea	—	—	—
Merionethshire	—	—	—
Monmouthshire & Newport	8	38	19·1
Montgomery-shire	1	4	15·4
Pembrokeshire	—	—	—
Radnorshire	—	—	—
Total: Wales	18	72	5·8

SUMMARY

Region and Executive Council	Number of health centres	Number of doctors	% of all doctors in area
Regional totals			
North Region	11	85	6·5
Yorkshire and Humberside Region	19	75	3·9
East Midland Region	7	45	3·4
East Anglia Region	4	16	2·3
South West Region	36	169	9·8
South East Region	31	149	2·0
West Midland Region	11	79	4·0
North West Region	12	70	2·7
Wales	18	72	5·8
Total: England and Wales	149	760	3·8

*This table relates solely to health centres provided under Section 21 of the National Health Service Act, 1946 (including 10 centres which were built before 1948 but which were approved as health centres when the Act came into force).

It excludes local health authority clinics, some of which have been adapted or extended specifically to provide accommodation for general medical practitioners, and which, although not provided under Section 21, furnish similar facilities to those in health centres. A notable example is the West Riding of Yorkshire where additional accommodation is provided in this way in 44 centres for 125 general practitioners. These represent 27% of the general practitioners in the county area.

TABLE 6

Schemes of attachment of health visitors and home nurses.
Position at 31 October, 1969: England and Wales

PART I: GENERAL PRACTITIONERS WORKING WITHIN ATTACHMENT SCHEMES

Type of staff attached	Number of General Practitioners working within		Total
	Full attachment schemes*	Other attachment schemes	
Health Visitors only	2,415	1,314	3,729
Home Nurses only	2,482	1,091	3,573
Health Visitors and Home Nurses	3,979	708	4,687
Total	8,876	3,113	11,989†

*Full attachment schemes are those in which a health visitor or home nurse is responsible for providing LHA Services to all patients on the lists of specified general practitioners with whom she has regular consultations. She is not limited to working within a geographical district.

†This represents 59% of the total of all unrestricted principals in England and Wales.

PART II: STAFF WORKING WITHIN ATTACHMENT SCHEMES

Type of staff attached	Number of staff working		Total
	Wholly within attachment schemes*	Partly within attachment schemes	
Health Visitors	2,181	973	3,154
Home Nurses S.R.N.	2,574	618	3,192
Home Nurses S.E.N.	362	120	482
Staff on combined Health Visitor/ Home Nurse duties	310	110	420
Total	5,427	1,821	7,248

*Includes part-time staff who perform no local health authority duties outside the attachment scheme.

APPENDIX G

HEALTH CENTRES

List of activities which may take place in a health centre and the accommodation which these may require.

Activity	Accommodation and facilities
1. Arrival of patients:	
(*a*) On foot	—
(*b*) By car	Car park
(*c*) By bicycle	Bicycle rack
(*d*) By or with pram	Pram shelter (visible from waiting area)
(*e*) By wheel chair	—
2. Reception	A single public entrance and a private entrance for staff Reception counters (possibly subdivided by practices)
3. Patient call system and telephone	Appropriate space
4. Record filing	Record filing area with easy access by receptionist
5. Waiting area	Waiting area (possibly subdivided by practices, preferably not separate rooms) Possibly a separate toddler play area and a crèche visible from reception Separate WCs for patients and staff
6. Secretarial and practice administration	Typist's office Administrator's office (in larger premises)
7. Consultation:	
(*a*) Interview	Consulting rooms with examination area
(*b*) Clinical examination	Separate examination rooms
8. Nursing and other delegated procedures: e.g. dressings, ear syringing, injections, venepuncture, blood pressure, weight, audiometry, cervical smear, mid-stream specimens of urine, electrocardiograph, simple tests on blood, urine and discharge	Treatment rooms (mainly for use by nurses) Provision for simple laboratory tests, electrocardiography, etc. Autoclave Provision for passing of specimens from patients' W.C.
9. Minor surgery	
10. Further management, e.g. re-appointments; internal referrals to nurse, health visitor, medical social worker; outside referrals to X-ray, pathology, out-patients, local authority	Offices for health visitors, social workers, home nurses
11. Advice and counselling by health visitors, social workers, etc.	Interview room for use by health visitors, medical social worker, psychiatric social worker
12. Health education activities:	
(*a*) Group discussions	Health education area
(*b*) Talks and films for classes	
(*c*) Displays	
(*d*) Announcements	
13. Clinics in preventive medicine:	
(*a*) Child health	Use of health education area, consulting rooms, etc.
(*b*) Ante- and post-natal including relaxation classes	
(*c*) Other Screening	
(*d*) Geriatric	
(*e*) Family planning	

14. Case discussion	Common room/library with facilities for refreshments
15. Teaching (in certain health centres) (*a*) Undergraduate student attachment programme	Such additional accommodation as may be appropriate
(*b*) Postgraduate vocational training (*c*) Student and in-service training schemes for local authority nurses, health visitors, medical social workers	Such additional accommodation as may be appropriate
16. Associated medical services (in larger health centres) e.g. dentistry, pharmacy, ophthalmic services, chiropody, physiotherapy and rehabilitation, simple pathology, casualty service	Separate accommodation as appropriate
17. Services	Storage, cleaners' room, heating plant, incinerator or waste disposal equipment

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